"People helping people help themselves"

Mitchell E. Daniels, Jr., Governor
State of Indiana

Indiana Division of Aging
402 W. WASHINGTON STREET, P.O. BOX 7083
INDIANAPOLIS, IN 46207-7083

E. Mitchell Roob, Jr, Secretary

Thank you for your interest in providing services for the Medicaid Home and Community-Based Services Waivers. Enclosed are the following documents:

- Adult Day Service Rates and Description
- ADA/Transportation Statement of Assurances & Compliance of Service
- Adult Day Service Level of Assessment/Evaluations List
- Adult Day Service Provision and Certification Standards and Guidelines
- Adult Day Service Survey Tool
- Nursing Facility Level of Care Waiver Provider Information website sheet
- Provider application for the Nursing Facility Level of Care Waiver (s)
- Provider Agreement (Schedule A)
- W-9 Tax Identification Number and Certification
- County Survey with a list of the 16 Area Agencies on Aging

Please complete the application, provider agreement, W-9, and county survey with dates and signatures and return them along with the specific documents and other information required for the service (s) for which you wish to be approved.

Please contact Ava Y. Taylor, Program Manager at (317) 232.7149 or Linda Wolcott, Certification Specialist at (317) 234.0373 with any questions you may have.

To request additional waiver documents, contact the Waiver Secretary at (317) 232.7122.

The completed application and attachments should be returned to:

Linda Wolcott, Waiver Operations
MS 21 Division of Aging
402 West Washington Street, Room W454
P.O. Box 7083
Indianapolis, Indiana 46207-7083

Enclosures

ADULT DAY SERVICES RATES effective 7/1/2007

This is a clarification of the manner in which Adult Day Services Units are to be utilized for clients on the Nursing Facility Level of Care Waivers (A&D and TBI)

The documentation for this memo is taken from the:
"**Provider Bulletin (BT200421) dated July 1, 2007**

SERVICE		UNIT	CAP RATE	CODE AND MODIFIER(S)	PRIOR AUTHORIZATION & AUDIT CRITERIA
Adult Day Service Level 1 (1/4 Hour)	0.25	Hour	$3.00	S5100 U7 U1	Max. 40 units/day. Single PA covers months and total cost of service listed on NOA.
Adult Day Service Level 2 (1/4 Hour)	0.25	Hour	$3.00	S5100 U7 U2	Max. 40 units/day. Single PA covers months and total cost of service listed on NOA.
Adult Day Service Level 3 (1/4 Hour)	0.25	Hour	$3.00	S5100 U7 U3	Max. 40 units/day. Single PA covers months and total cost of service listed on NOA.

*** 10 Hour per day Maximum ***

TRANSPORTATION

Transportation is an optional service and reimbursed under a separate contract rate.

Adult Day Services transportation furnished by the provider, either directly or by contract, shall meet transportation requirements as defined in the following paragraphs.

A "unit of transportation" is not included in the Adult Day Service levels of service reimbursement. A "unit of transportation" includes all administrative costs and all provider related costs associated with the trip. A "unit of Adult Day Service transportation" is one of the following:

1) A round trip for the transportation provider
2) The case manager shall negotiate a unit rate that is reasonable and based on distance and riders. The unit rate may vary between participants.

SERVICE	UNIT		CAP RATE	CODE AND MODIFIER(S)	PRIOR AUTHORIZATION & AUDIT CRITERIA
Transportation Adult Day Service	1	Round trip	$17.06	T2003 U7	Max 2 trips/day. Separate PA covers each month and monthly cost of service as listed on NOA

STATEMENT OF ASSURANCES AND COMPLIANCE

FOR THE SERVICE OF ADULT DAY SERVICES FOR THE INDIANA MEDICAID HOME AND COMMUNITY BASED SERVICES PROGRAM

As a qualified entity for Adult Day Services and as a duly appointed representative of the entity, I assure that personnel providing Adult Day Services for will abide by the following requirements:

- All applicable federal, state, county, and municipal regulations that govern the operations of this entity;
- All FSSA laws, rules, policies;
- All applicable licensures or certifications; and
- Adherence to the *Americans with Disabilities Act* (ADA), ADA Standards for Accessible Design available at**:** **http://www.usdoj.gov/crt/ada/adahom1.htm**

Name of Entity: _____

Waiver Provider Number (if applicable):_____

Medicaid Provider Number (if applicable):_____

Typed or Printed Name of Authorized Representative: _____

Title: _____

Signature: _____ Date: _____

Complete and return to:

Linda Wolcott, Waiver Operations
MS 21 Division of Aging
402 W. Washington Street, W454
P.O. Box 7083
Indianapolis, IN 46207-7083

STATEMENT OF ASSURANCES AND COMPLIANCE

FOR THE SERVICE OF TRANSPORTATION FOR THE INDIANA MEDICAID HOME AND COMMUNITY BASED SERVICES PROGRAM

As a qualified Adult Day Services entity for the service of transportation and as a duly appointed representative of the entity, I, assure that individual personnel providing transportation for said program will abide by the following requirements:

- Have a safe and legal driving record;
- Have valid auto insurance, including liability insurance;
- Have properly maintained vehicle;
- Have a valid Indiana Operator's license under IC 9-24-1-1 and IC 9-24-3 for individuals operating private vehicles;
- Have a valid Indiana Chauffeur's license under IC 9-13-2-21 and IC 9-24-4 or an Indiana Public Passenger Chauffeur's license IC 9-24-1-3 and IC 9-24-5 when operating a vehicle designed to transport fewer than 15 people; and
- Have a valid Indiana Commercial license IC 9-13-2-31 and IC 9-24-6 when operating a vehicle designed to transport a minimum of 15 people.

I assure that the service of Transportation under the waiver will not be used for medical appointments.

Name of Entity: _____

Waiver Provider Number (if applicable):_____

Medicaid Provider Number (if applicable):_____

Typed or Printed Name of Authorized Representative: _____

Title: _____

Signature: _____ Date: _____

Complete and return to:

Linda Wolcott, Waiver Operations
MS 21 Division of Aging
402 W. Washington Street, W454
P.O. Box 7083
Indianapolis, IN 46207-7083

Level of Service Assessment/Evaluation - Full List of Items

Adult Day Service

Client: _____ Date: _____

This document contains Protected Health Information which is governed by the Health Insurance Portability and Accountability Act (HIPAA) and may only be disseminated to authorized individuals!

PERSONAL CARE - Health Assessment	Points
Requires no assistance	0
Requires prompting and cueing	1
Requires one assistant with personal hygiene	2
Requires occasional sponge baths at center less than 3 times weekly	2
Requires one assistant and is frequently incontinent	3
Requires two or more assistants for personal hygiene 3 or more times weekly	3
Requires bath, partial bath, or shower on daily basis	3

AMBULATION - Health Assessment	Points
Ambulates / transfers independently with or without device	0
Requires stand by assistance when using devices to ambulate	1
Requires one person hands on assistance to ambulate / transfer	2
Requires two person hands on assistance to ambulate / transfer	3

FALLS - Health Assessment	Points
Low risk for fall	1
Medium risk for falls (requires stand-by assist 3 or more times weekly unsteadiness, weakness, seizures)	2
High risk for falls (requires daily stand by assistance at all times)	3

NUTRITION - Health Assessment	Points
Nutrition maintained adequately with center meal and eats independently or with minimal assistance	0
Special diet restriction and / or substitutes or supplements requiring staff intervention	2
Requires supervision, coaxing, or quiet dining area to maintain adequate nutrition	2
Requires special preparation of diet and / or direct oversight by staff (unstable diabetic, high risk of choking, puree, tube feeding)	4

NURSING SERVICES- Health Assessment	Points
Health care needs / medication coordination handled by participant or caregiver	0
May have multiple health problems but is stable requiring only routine screening (blood pressure-B/P weekly, monthly weight)	1
Requires direct oversight or administration of PRN medication	1
Requires administration of medicines 1-3 times daily	2
Requires daily intervention (B/P, oxygen saturation, etc.)	2
Requires daily exercise or therapy regimen for an insult or injury occurring within the last 6 months	2
Requires at least weekly enema or manual removal of bowel impaction	2
Requires administration of 5 or more different medications daily	3
Requires administration of medicine through injection or tube daily	3
Requires invasive nursing procedures to maintain health (fluctuating blood sugar monitoring, wound irrigation, trachestomy suctioning, etc.) daily	4
Requires sterile nursing procedures (dressing changes, catheter care, etc.) daily	4
Medically fragile (fluctuating or complex conditions requiring daily intervention by licensed nurse)	4

Level of Service Assessment/Evaluation - Full List of Items

Adult Day Service

Client: _____ Date: _____

This document contains Protected Health Information which is governed by the Health Insurance Portability and Accountability Act (HIPAA) and may only be disseminated to authorized individuals!

ORIENTATION - Cognitive Assessment	Points
Always oriented to time, place, and / or person	0
Not oriented to time, place, and / or person no more than 3 times weekly	1
Not oriented to time, place, and / or person 3 or more times weekly	2
Not oriented to time, place, and / or person on a daily basis	3

MEMORY - Cognitive Assessment	Points
No memory problems noted	0
May have short term and / or long term memory problems but responds to cueing	1
Has impaired memory requiring level of staff intervention 3 or more times weekly	2
Has severely impaired memory requiring frequent daily staff intervention	3

DIRECTIONS - Cognitive Assessment	Points
Self directed	0
Requires minimal reassurance and / or redirection	1
Requires reassurance and / or redirection 3 or more times weekly	2
Requires daily reassurance and / or redirection	3

DECISIONS - Cognitive Assessment	Points
Decision making is intact	0
Cognitively impaired decision making requires supervised environment	1
Cognitively impaired decision making with increased risk of harm to self	2
Cognitively impaired decision making puts self at grave risk of bodily harm	3

AGITATION - Cognitive Assessment	Points
No agitation noted	0
Agitated no more than 3 times weekly	1
Agitated 3 or more times weekly	2
Agitated daily	3

WANDERING - Cognitive Assessment	Points
No demonstrated potential to wander	0
Demonstrated potential to wander from group due to cognitive impairment	1
Demonstrated potential to wander from building due to cognitive impairment	2
Demonstrated daily desire to leave building due to cognitive impairment	3
Demonstrated unpredictable elopement due to cognitive impairment	4

CARE NEEDS - Psycho-social Assessmt	Points
Individual and / or caregiver able to coordinate / address care needs and issues	0
Individual / caregiver needs education and /or minimal supportive counseling to coordinate / address care needs & issues less than 3 times weekly	1
Individual / caregiver requires education and / or supportive counseling to coordinate / address care needs & issues 3 or more times weekly	2
Individual / caregiver requires daily education and / or supportive counseling to coordinate / address care needs & issues	3

Level of Service Assessment/Evaluation - Full List of Items

Adult Day Service

Client: _____ Date: _____

This document contains Protected Health Information which is governed by the Health Insurance Portability and Accountability Act (HIPAA) and may only be disseminated to authorized individuals!

INITIATION - Psycho-social Assessmt	Points
Self initiates contact / relationship with others	0
Initiates contact with others with staff intervention less than 3 times weekly	1
Isolates self by withdrawal from group or interpersonal contact	2
Frequent absenteeism and / or refuses interpersonal contact daily	3

BEHAVIOR - Psycho-social Assessment	Points
Behavior socially appropriate	0
Engages in socially inappropriate behaviors	2
Interpersonal conflict with others 3 or more times weekly	3
Self neglect or abuse	3
Physically and / or verbally abusive to others, but responds appropriately to staff interventions	3

Emotional	Points
Emotionally stable	0
Emotional needs met by caregiver / outside therapist	1
Assess for and refer as appropriate for indicators such as depression, chemical abuse, suicidal ideation, psychosis if risk factors present	2
Staff provide intervention or participates in treatment plan for such issues as depression, chemical abuse, suicidal ideation, psychosis	3
Physically and / or verbally abusive to others but does not respond to staff intervention	4

ACTIVITY NEEDS - Engagement	Points
Activity needs generally met by large group activities	1
Activity needs require small group or individual structure	2
Activity needs require one-on-one structure	4

PARTICIPATION - Engagement	Points
Requires no staff prompting to participate	0
Requires less than 3 times weekly staff prompting to participate	1
Requires 3 or more times weekly staff prompting to participate	2
Requires daily staff prompting to participate	3

COMMUNICATION - Engagement	Points
Communicates needs	0
Communicates needs with minimal difficulty	1
Communicates needs in one-on-one exchanges	2
Unable to communicate needs	3

Form Instructions

Circle all the descriptors that apply. Some items may become disqualifiers for admission. (For example, if facility is unable to do intensive nursing care or unable to provide a safe environment for a participant who is an unpredictable elopement risk.)

If it is documented the applicant cannot benefit from the congregate nature of this program the director/admission coordinator has the discretion to deny admission.

If the level of service required by the applicant exceeds the capacity of staffing patterns and facility, the director/admission coordinator has the discretion to decline admission.

All descriptors coded 4 will automatically trigger level II enhanced services. Coded 4 descriptors may trigger disqualification for admission. They may also indicate need for discharge planning dependent on staffing patterns and facilities.

Potential Scoring Point for Levels of Service:
(May be submitted for change no more than every 30 days).

Basic	1-11
Enhanced	12-22
Intensive	23-36

Any composite score greater than 36 points may require monthly review by the provider for participant appropriateness for day services.

Adult Day Services

Provision and Certification Standards
For
The Aged and Disabled Waiver and Traumatic Brain Injury Waiver
FSSA Waiver Services
Division of Aging

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I. Definitions

A. Adult Day Services

Adult Day Services (ADS) are community based group programs designed to meet the needs of adults with impairments through individual plans of care. These structured, comprehensive, non-residential programs provide a variety of health, social, recreational and therapeutic activities, supervision, support services, and in some cases personal care. Meals and/or nutritious snacks are required. The meals cannot constitute the full daily nutritional regimen. Each meal must meet 1/3 of the Dietary Reference Intake. These services must be provided in a congregate, protective setting. By supporting families and other caregivers, adult day services enable participants to live in the community.

Adult Day Services assess the needs of participants and offer services to meet those needs. Participants attend on a planned basis. A minimum of 3 hours per day to a maximum of 12 hours per day shall be allowable. There are three levels of adult day services: Basic, Enhanced, and Intensive.

B. Other Definitions Related to the Service

For purposes of these Certification Standards for the FSSA Waiver Services HCBS Medicaid Waiver Programs for persons who are aged or medically disabled, the following definitions will apply:

"Activities of Daily Living (ADL)" - those personal functional activities required by an individual for continued well-being including mobility, dressing, bathing, eating, toileting, and transferring.

"Adult Day Services Center" – hereafter referred to as "Adult Day Services Provider" -- a provider of Adult Day Services, under the A&D waiver, who is enrolled in the HCBS Medicaid Waiver Programs for persons who are aged or medically disabled.

"Advance Directive" - the legal document signed by the participant, giving instructions for health care should she/he no longer be able to give directions regarding her/his wishes. The directive gives the participant the means to continue to control her/his own health care in any circumstance.

"Aging in Place" - residing in a care environment that will provide the participant with a range of care options as the needs of the participant change. Aging in place does not preclude assisting a participant in relocating to a new care environment, if necessary.

"Area Agency on Aging" (AAA) - an established public agency within a planning and service area designated under Section 305 of the Older Americans Act which has responsibility for assisting individuals in the Waiver process. For the purpose of these Certification Standards, AAAs contract with the state to

perform specific activities in relation to administration of the FSSA Waiver Services HCBS Medicaid Waiver Program.

“Behavioral Interventions” - those interventions that will modify the participant’s behavior or environment.

“Caregiver” - any person responsible for providing care and services to participants outside of the Adult Day Center facility, including the family caregiver, and any substitute or caregiver designated to provide care and services to participants.

“Case Manager” – Provides case management services to HCBS Medicaid Waiver participants as described under “Case Management Services”.

“Case Management Services”- Case management is the single most important element in accomplishing these goals for participants eligible for Medicaid waivers. Medicaid waiver ongoing case managers coordinate and integrate all services required in a participant’s plan of care, link participants to needed services, and ensure that participants continue to receive and benefit from services. Waiver case managers enable participants to receive a full range of services needed because of a medical condition, in a planned, coordinated, efficient, effective manner. Case management is required in conjunction with the provision of any home and community-based service.

The components of case management are:

a. Level of Care Assessment
b. Medicaid Eligibility
c. Plan of Care Development
d. Monitoring

Case Management services for persons who are on Nursing Facility Level of Care (NF-LOC) Medicaid waiver are provided by FSSA certified case managers. The sixteen local Area Agencies on Aging (AAA) serve as the single point of entry for the NF-LOC Medicaid waivers. A case manager from the AAA will be assigned to an applicant. After an applicant has been determined to meet eligibility criteria and approved to receive NF-LOC Medicaid waiver services, he or she may choose to retain their current AAA case manager or choose a non-AAA or independent case manager, for on-going case management services.

“Certification Standards” - the specific Adult Day Services standards established for all participants and providers who utilize any of the Medicaid Home and Community-Based Services (HCBS) Waiver Programs for persons who are aged or medically disabled.

“Chemical Restraint” – use of any chemical method used to restrict the participant's activities and behavior.

“Choice” - a participant has viable options that enable him/her to exercise greater control over his/her life.

“Complaint” - an allegation that a provider has violated these Certification Standards or dissatisfaction relating to the condition of the adult day service or the participant(s).

“Consumer” – also referred to as “Participant” – an individual who is eligible for the FSSA Waiver Services HCBS Medicaid Waiver Program, and receives those services in an Adult Day Service setting for whom the service of ADS is paid through the FSSA Waiver Services HCBS Medicaid Waiver Program. "Participant" includes former participants when examining complaints about admissions, re-admissions, or discharges. For decision-making purposes, the term "participant" includes the participant’s surrogate decision-maker in accordance with state law or at the participant’s request.

“Consumer Contract” - an agreement or contract completed by the Adult Day Services provider for each potential participant that includes: a description of the services to be provided to the participant; a description of the contract modification process; a description of the complaint resolution process; specific policies and procedures; and other general information.

“Consumer Risk Contract”-. This contract will be initiated by the provider for each participant and will address unusual situations in which a participant's assertion of a right, behavior, or preference exposes the participant or someone else in the program to a real and substantial risk of injury. The Consumer Risk Contract will identify and accommodate a participant's need in a way that is acceptable to the provider, primary caregiver, and participant. It will include an explanation of the cause(s) of concern; the possible negative consequences to the participant and/or others; a description of the participant's preferences; possible alternatives or interventions to minimize the potential risks associated with the participant's preferences/action; a description of the services that the adult day center will provide in order to accommodate the participant's choice or to minimize the potential risk and services other entities will provide to accommodate for their choice or to minimize this risk; final agreement reached by all parties.

“Dignity” - providing support in such a way as to validate the self-worth of the individual. Dignity is supported by designing a structure that allows personal assistance to be provided in privacy and delivering services in a manner that shows courtesy and respect.

“Division of Aging” -- a division within Family and Social Services Administration in which the Bureau of Aging and In Home Services, the Bureau of Quality Improvement Services are located, and within which the FSSA Waiver Services Program operates.

“Elderly” or “**Aged”** - any person age 65 or older who is in need of care.

“FSSA Waiver Services”- the divisions within the Family and Social Services Administration under which the HCBS Medicaid Waiver Program is administered. For purposes of this document, FSSA Waiver Services may also include any designee providing oversight and/or collaboration regarding the provision of ADS under the A&D Waiver. This may include other Bureaus under FSSA or may include contractors or other entities to which FSSA Waiver Service duties have been formally delegated.

“HCBS” – Home and Community Based Services

“HCBS Medicaid Waiver Provider Agreement” - a provider agreement signed by an Adult Day Service provider who is enrolled in the HCBS Medicaid Waiver Program.

“Independence” - free from the control of others and being able to assert one's own will, personality and preferences within the parameters of the facilities’ rules or consumer contract.

“Individual Care Plan” – the plan of care and activities arranged for the participant by the Adult Day Center staff, the participant, and caregivers of the participant.

“Level of Service” - the specific level of service that the provider is authorized to provide in accordance with the participant’s plan of care and based on the assessed impairment level of the participant.

“Level of Service Assessment” or **“Level of Service Assessment Tool”** - the assessment instrument that is utilized to determine the appropriate level of service to be provided and paid according to three (3) impairment levels, with Level 1 being the least impaired/most independent and Level 3 being the most impaired/least independent.

“Medical Emergency” - a change in medical condition that requires immediate care of a level or type that the provider is unable to provide or behavior that poses an imminent danger to the participant or to other participants in the facility.

“Medically Disabled” or **“Disabled”** - a person who is 18 years of age or older with a physical, cognitive, or emotional impairment which, for the individual, constitutes or results in a functional limitation in activities of daily living. The individual must meet nursing facility level of care to obtain adult day services under the A&D Waiver.

“Medication Management” - the provision of reminders or cues, the opening of pre-set commercial medication containers, and/or providing assistance in the handling or ingesting of medication that is not a controlled substance. Provision of medication management services shall be at the direction of a participant who is competent, but otherwise unable to accomplish the task him/herself due to

physical infirmity. In the event a participant is not competent, or in instances where competence is in question, a competent individual who is responsible for the health and care of the participant may direct the appropriate assistance for him or her. For purposes of this definition, "medication" means prescription medications.

"OMPP" - the Office of Medicaid Policy and Planning within the Indiana Family and Social Services Administration.

"Ombudsman" - a representative of the Office of the State Long Term Care Ombudsman who serves as an advocate for participants, with responsibilities that include investigation and resolution of complaints on behalf of participants of Adult Day Center services.

"Participant" – also referred to as "Consumer" – see definition for "Consumer"

"Physical Restraint" - any manual method or physical or mechanical device, material, or equipment attached to, or adjacent to, the participant's body which the participant cannot easily remove and restricts freedom of movement or normal access to his/her body. Physical restraints include, but are not limited to, leg restraints, soft ties or vests, hand mitts, wheelchair safety bars, lap trays, any chair that prevents rising, and geri-chairs.

"**Plan of Care**" **or "POC"**- the written plan developed by the case manager, provider, and participant or others on participant's behalf, in which the case manager documents the proposed Adult Day Services, the Medicaid State Plan services, as well as other medical services and social services and informal community supports that are needed by the participant to ensure his/her health and welfare. It also includes the comprehensive assessment to establish supports and strategies intended to accomplish the individual's long term and short term goals by accommodating the financial and human resources offered, as well as behavioral-related assistance to the individual through paid provider services or volunteer services, or both, as designed and agreed upon by the individual. (Division of Disability, Aging, and Rehabilitative Services; 460 IAC 1.1-3-17)

The initial plan of care must be approved by the FSSA Waiver Services Waiver Specialist prior to the initiation of Medicaid-funded Waiver services. The plan of care must be reviewed and updated by the case manager as needed but no less often than every ninety (90) days for each Adult Day Service participant, regardless of Service Level.

"Provider" – also referred to as "Center" -- a partnership, corporation, or other legal entity, which enters into an agreement with FSSA Waiver Services HCBS Medicaid Waiver Program to provide Adult Day Services to HCBS Medicaid Waiver Program participants.

"Psychoactive Medications" - various medications used to alter mood, anxiety, behavior or cognitive processes. For the purpose of these Certification Standards, they include, but are not limited to, anti-psychotics, sedatives, hypnotics, and anti-anxiety medications.

"Rights" or "Participant's Rights" - those rights as defined in these Certification Standards.

"Self-Administration of Medication" - the act of a participant placing a medication in or on his/her own body. This means the participant manages and takes his or her own medications, in that the participant identifies the medication and the times and manners of administration, and places the medication internally or externally on his/her own body without assistance. This may include reminders, cues, and/or opening of medication containers by staff when requested by a participant. Assistance with prescription eye drops can only be given by an LPN or RN or would need to be self administered by the participant.

"Staff" or "Provider" – any person responsible for providing care and services to participants while in the facility, including the provider, case managers, and staff of the Adult Day Service Center.

"Staff – Direct Care Staff" – any member of the Adult Day Center staff who is providing direct or "hands-on" care to the participants including transferring, feeding, toileting, bathing, dressing, and other activities of daily living.

"Staff – Indirect Care Staff" – any member of the Adult day Center staff who serves the participants in an "indirect" way (i.e. management, janitorial, or food service/prep staff).

C. Definitions of the Levels of Adult Day Services

Adult Day Services are provided at three different, designated levels of service.

1. Basic Adult Day Service (Level 1) includes:
    a. Monitor and/or supervise all Activities of Daily Living (ADL's are defined as dressing, bathing, grooming, eating, walking, and toileting) with hands on assistance provided as needed
    b. Comprehensive, therapeutic activities
    c. Assure health assessment and intermittent monitoring of health status
    d. Monitor medication / or medication administration
    e. Ability to provide appropriate structure and supervision for those with mild cognitive impairment.
    f. Staff to Participant ratio not to exceed 1:8

2. Enhanced Adult Day Service (Level 2) includes:

    Basic (Level 1) service requirements must be met.
    Additionally:

a. Provide hands-on assistance with 2 or more ADL's or hands-on assistance with bathing or other personal care
b. Health assessment with regular monitoring or intervention with health status
c. Dispense or supervise the dispensing of medications to participants
d. Psychosocial needs assessed and addressed including counseling as needed for participants and caregivers
e. Ability to provide therapeutic structure, supervision and intervention for those with mild to moderate cognitive impairments.
f. Staff to Participant ratio not to exceed 1:6

3. Intensive Adult Day Service (Level 3) includes:

Basic (Level 1) and Enhanced (Level 2) service requirements must be met. Additionally:

a. Hands on assistance or supervision with all ADL's and personal care
b. One or more direct health intervention(s) required
c. Rehabilitation and restorative services including Physical Therapy, Speech Therapy, Occupational Therapies coordinated or available
d. Ability to provide therapeutic intervention to address dynamic psychosocial needs such as depression or family issues effecting care
e. Ability to provide therapeutic interventions for those with person with moderate to severe cognitive impairments
e. Staff to Participant ratio not to exceed 1:4

II. Provider Requirements

A. Provider Eligibility and Enrollment

The ADS provider must follow the current procedures of Provider Application and eligibility determination as described by FSSA Division of Aging and/or designee. All steps must be followed and documented, and all standards required for Medicaid Waiver Provider status must be met in order to obtain certification. The burden of proof shall be upon the provider to establish compliance with the Certification Standards.

An ADS center or provider must be a legal entity authorized by the Indiana Secretary of State to do business in the State of Indiana. The center must be in a facility and is not permitted to be conducted in a private residence. It will be the responsibility of the center to ensure the state that all direct-care staff meet the level appropriate eligibility requirements. Documentation should be kept in a center's file, and should be available to FSSA Waiver Services or designee at any point in the certification and ongoing monitoring process of that center. FSSA Waiver Services or designee may deny an application for noncompliance with any such requirements.

In addition, the enrollment application for providers of ADS shall include the following information to be submitted by the provider applicant:

1. The maximum participant capacity requested;

2. The service level classification being requested with information and supporting documentation regarding qualifications, relevant work experience, and training for all direct-care staff as required by FSSA Waiver Services or designee;
3. A floor plan of the facility showing exits, wheelchair ramps if applicable, smoke detectors and extinguishers. The floor plan shall show exits and directions for vacating the premises;
4. Written plan describing the planned operation of the ADS, including the use of volunteers

Enrollment as a member of the Indiana Association of Adult Day Services is recommended, but not required. The Association may be beneficial in providing ADS start-up kits, training, and other useful resources. Find more information at www.iaads.net.

B. Certification of ADS Provider and Facility

An on site review of the facility will be completed by an inspector, designated by FSSA Waiver Services, in order to assess the Center's ability to safely and successfully provide ADS care of the participants. The inspector or designee will document that the following criteria are met during this initial certification inspection.

On-site provider files including documentation that all provider requirements are met. (i.e.: liability insurance, current staff initial physical exams, etc.) will be present, and available for review by inspector.

1. Facility Requirements

    a. The facility and grounds shall be safe for all participants.

    b. The facility shall:

        1. Provide at least forty (40) square feet of indoor space for each client, including kitchen prep area, but excluding hallways, offices, restrooms and storage rooms; space must be appropriate to meet care needs.
        2. Provide additional space adequate for rest area, special therapies, and designated space to isolate the ill. Centers doing personal care must have designated space to provide this care in a manner that maintains safety, confidentiality, privacy and promotes dignity of the participants;
        3. Provide comfortable, safe furniture and adaptive equipment as needed to be used by participants. Furniture shall be designed as appropriate for use by persons with physical disabilities;
        4. Provide adequate illumination, sound transmissions, heating, cooling, ventilation, and maintenance to facilitate safe, comfortable conditions. Incandescent light bulbs shall be protected with appropriate covers;

5. Be approved for use by the State Fire Marshall's Office and inspected by the local fire department with inspection kept on file;
6. Be approved for use and inspected by the Indiana Department of Health with inspections kept on file;
7. Be designed, constructed, and maintained according to all applicable local, state and federal health and safety regulations;
8. Conform to the requirement of Americans with Disabilities Act of 1990 in order to accommodate individuals with disabilities. The standards include the following:
    - Designated parking is available;
    - Sidewalks have a continuous, uninterrupted surface made of firm, non-slip materials;
    - Ramps (exterior and interior) have a maximum gradient of one (1) foot rise in twelve (12) feet, with handrails thirty-four to thirty-eight (34-38) inches high extending twelve (12) inches beyond the ramp and ramps have a non-slip surface;
    - Entrance has a level approach platform;
    - Entrance door is thirty-two (32) inches wide;
    - Entrance threshold is flush or beveled;
    - Floor materials are non-slip;
    - Stairs have handrails thirty-four to thirty-eight (34-38) inches high;
    - Must have 1 toilet for every 10 persons served. Toilet facilities are floor level with corridor, and at least one compartment has 2 thirty-six (36) inch high grab bars.
    - Toilet compartment must have (36) inch wide out swinging door

c. If the Adult Day Service center is housed in a building with other services or programs the provider shall assure that a separate, identifiable space is available during operational hours.

Each ADS facility shall meet all applicable local zoning and building codes, and state and local fire and safety regulations for a public facility. The building and furnishings shall be clean and in good repair. Grounds shall be well maintained. Yard, approved exits and exterior steps shall be accessible and appropriate to the condition of the participants. Walls, ceilings, and floors shall be of such character to permit frequent washing, cleaning, or painting. There shall be no accumulation of garbage, debris, rubbish or offensive odors. All participants shall have unobstructed passageways throughout the facility and corridors and hallways shall be wide enough to accommodate a walker or wheelchair.

2. Safety Requirements

At least one working fire extinguisher shall be in a visible and readily accessible location on each floor, including basements, and shall be inspected by staff at least once a year. Fire extinguishers shall be tagged, with a staff signature and date of inspection. There shall also be current readily available basic first-aid supplies and a first-aid manual.

Smoke Detectors shall be installed in accordance with the manufacturer's listing and be installed in hallways or access areas where participants congregate, any interior designated smoking area, and in basements. In addition, in two-story facilities, smoke detectors must be installed at the top of the stairway to the second floor. Ceiling placement of smoke detectors is recommended. Detectors shall be equipped with a device that warns of low battery when battery operated or with a battery backup if hard wired. All smoke detectors are to be maintained in functional condition. Battery operated smoke detectors must be tested monthly and batteries changed at least once per year.

All exit doors and interior doors shall have simple hardware that cannot be locked against exit without an obvious method of operation, and which does not require a key when locked against exit. For example, a key pad lock can be used requiring a code to enter and exit. In addition, there is to be a means for emergency exit which does not require application of the code.

A public water supply shall be utilized if available. If a non-municipal water source is used, minimum water quality standards must be met. Septic tanks or other non-municipal sewage disposal system shall be in good working order. Commodes shall be emptied frequently and incontinence garments will be disposed of in closed containers. In addition, garbage and refuse shall be suitably stored in clean, rodent-proof, covered containers, pending weekly removal.

Sanitation for pets and other domestic animals shall be adequate to prevent health hazards. Proof of rabies or other vaccinations required by a certified veterinarian shall be maintained on the premises for pets. Pets not confined in enclosures must be under control and must not present a danger to participants or guests.

Hazardous Materials: Flammable and combustible liquids and hazardous materials shall be safely and properly stored in original, properly labeled containers or safety containers and secured in areas to prevent tampering by participants or vandals. Cleaning supplies, poisons and insecticides shall be properly stored in original, properly labeled containers in a safe area away from food preparation and storage areas, dining areas, and medications.

Universal precautions for infection control should be followed during direct care with participants. Hands and other skin surfaces must be washed immediately and thoroughly if contaminated with blood or other body fluids.

Bathroom specifications: Participant bathrooms must provide individual privacy and have a finished interior; a functioning window or other means of ventilation; and a

window covering. The rooms must be clean and free of objectionable odors. Toilets and sinks (and tubs or showers if bathing is offered), must be in good repair. Bathrooms must have hot and cold water at each sink, tub, and shower in sufficient supply to meet the needs of the participants. Hot water temperature shall be supervised for persons unable to regulate water temperature. Shower curtains and doors shall be clean and in good condition. Non-slip floor surfaces shall be provided in tubs and showers. There must be safe and secure grab bars for toilets, tubs, and/or showers for participant's safety. Bathrooms must have adequate supplies of toilet paper and soap.

Meal specifications: Nutritious meals must be offered daily. Nutritious snacks and liquids should be available and offered to fulfill each participant's nutritional requirements. Special consideration must be given to participants with chewing difficulties and other eating limitations. Food shall not be used as an inducement to control the behavior of a participant. Special diets are to be followed as prescribed in writing by the participant's physician/nurse practitioner. Food should be stored and maintained at the correct temperature in a properly functioning refrigerator. Utensils, dishes and glassware shall be washed by dishwasher or by hand in hot soapy water, rinsed, and stored to prevent contamination.

Certain safety requirements will be followed in accordance with the individual specifications outlined in a participant's Consumer Risk Management Contract. This contract will be initiated by the provider for each participant, and will address unusual situations in which a participant's assertion of a right, behavior, or preference exposes the participant or someone else to a real and substantial risk of injury. The Consumer Risk Contract will identify and accommodate a participant's need in a way that is acceptable to the provider, and participant. It will include an explanation of the cause(s) of concern; the possible negative consequences to the participant and/or others; a description of the participant's preferences; possible alternatives or interventions to minimize the potential risks associated with the participant's preferences/action; a description of the ADS services that the provider will provide in order to accommodate the participant's choice or to minimize the potential risk and services other entities will provide to accommodate for their choice; final agreement reached by all parties. The provider will involve the participant, the case manager, and others involved in participant's care in the development, implementation, and review of the risk assessment.

Fire and Emergency Evacuation: An emergency evacuation plan shall be developed, posted and rehearsed at least quarterly with participants and staff. All staff shall be required to demonstrate the ability to quickly evacuate all participants from the facility to the closest point of safety, which is exterior to, and away from the structure. If there are problems in demonstrating this evacuation time, conditions may be applied to the HCBS Medicaid Waiver Provider Agreement that include, but are not limited to, reduction of participants under care, or increased fire protection. The center will provide, keep updated and post a floor plan containing room sizes, fire exits, smoke detectors and fire extinguishers, and evacuation routes. A copy of this drawing will be submitted with the application and updated to reflect any change. There must be a second safe means of egress. There will be at least one flashlight available on each floor for emergency lighting that is checked for power on a monthly basis and given new batteries if needed.

Smoking regulations will be adopted to allow smoking only in designated areas. Smoking will be prohibited in areas where oxygen is used. Ashtrays of noncombustible material and safe design shall be provided in areas where smoking is permitted.

Insurance: The center shall maintain liability insurance of at least one hundred thousand dollars per occurrence to cover damage or loss of the participant's property if due to negligence of the insured. The center shall also maintain insurance covering Injury or harm to the participant resulting from the provision of services or failure to provide needed services and incidents occurring in the ADS facility or on the facility's premises.

C. Staff Requirements

If the Adult Day Service is housed in a building with other services or programs or is a part of a larger organization, the provider shall assure that separate identifiable staff is available during operational hours.

At least 2 paid staff must be in the facility and available at all times when more than 1 participant is present. (Second staff person is not required to provide direct care services to day service program unless there are more than 8 clients present for Basic Adult Day Service clients (Level 1), more than 6 for Enhanced (Level 2), and more than 4 for Intensive (Level 3).

The ADS must provide documentation to the state that all staff meet certain standards, including but not limited to: all staff must be eighteen (18) years of age or older, ability to pass a criminal record check, must be literate and demonstrate the understanding of written and oral orders. Direct care staff must have the ability to communicate with participants and their caregivers. They must be able to respond appropriately to emergency situations. They must have a clear understanding of job responsibilities, have knowledge of participant's care plans and be able to provide the care specified for each participant's needs. Indirect care staff consisting of administrative and management staff must be able to communicate with participants, their families and/or caregivers, case managers, and physicians. All staff must have an initial physical, including a TB test, and will provide a statement from a physician indicating date of exam and testing and that they are free from TB. All staff must have annual TB testing thereafter with documentation kept on file. Copies of all such medical records must be in the personnel file for each staff member.

Administrator or Program Director must appoint staff person to supervise program in the absence of director.

D. Training Requirements for all Staff

All staff shall receive orientation prior to providing Adult Day Services, including program policies and procedures, participant rights, demonstration of evacuation procedures, locations of participant records, emergency contact numbers, and medication cabinet and key. If volunteers are used as staff, their orientation and training requirements must be the same as paid staff. The provider will keep documentation of the certifications, training and orientation of all staff.

1. Training required of all direct care and administrative staff of adult day services providing Basic (Level 1) care includes the following:
    - Basic first aid. (medical personnel such as RN or physician are excluded as this is within their scope of practice)
    - Cardiopulmonary resuscitation (CPR) certification.
    - Training on emergency procedures, implementation and responsibilities including fire and safety procedures.
    - Observation, documentation and communication skills.
    - Working with older persons and/or persons with disabilities.
    - Aging process, including normal psychological, social and physiological changes of aging.
    - Basic information concerning medical treatments, age-related diseases, illnesses, drug interactions, medical terms, functional and behavioral issues, nutritional and end of life issues.
    - Development and use of individualized participant service plan to maximize independence and prevent secondary impairments.
    - Regular (at least quarterly) in-service training, which meets individual and collective staff needs and enhances job performance and ability to provide quality care.
    - Training in recognizing signs of abuse, neglect and exploitation and reporting to appropriate agencies.
    - Training on universal precautions.
    - Training on cognitive impairment or other special needs of population served.
    - Proper food handling and food safety.

2. Training requirements of adult day services direct care and administrative staff (if administrative is 2nd staff available at times or is included in staff/client ratio) of day centers providing Enhanced (Level 2) care include all of the Basic (Level 1) requirements, plus the following:
    - Training in personal care services
    - Appropriate personal care attendants at Enhanced (Level 2) shall be certified adult day service program assistants, certified nursing assistants, qualified medication aides, certified home health aides or licensed nurses.
    - Adult Day Service attendants will maintain their continuing education requirements unique to their certification and will maintain current certificates.

3. Training requirements of adult day services direct care and administrative staff (if administrator is 2nd staff available at times or is included in staff/client ratio) of day centers providing Intensive (Level 3) care include all of the Basic (Level 1) and Enhanced (Level 2) requirements, plus the following:
    - In-service training regarding special care needs of populations served, such as appropriate two person assist for transfers, moderate to severe cognitive impairments that put participant at high risk of

elopement, choking or outbursts; or multiple vital sign monitoring more than once a day, etc. In-service for personal care assistants on special care needs of population served such as colostomy skin care, enema administration, tube feeding, etc. commensurate with level of professional training or certification assistant has.

E. Level Specific Staffing Requirements

Basic (Level 1)

1. The staff and client ratio shall be a minimum of one (1) to eight (8). Volunteers are not included in the staff ratio unless they are professionally trained and/or certified in a health occupation and oriented and trained as staff.

2. An RN or LPN with RN oversight shall be available as a consultant and for health education needs, assessments, medication oversight or administration, health promotion, prevention of illness and health screening.

3. Staff providing or assisting with activities will receive additional training in leading therapeutic group activities that meet the needs of person served and maximize their independence.

Enhanced (Level 2)

1. A staff and client ratio shall be a minimum of one (1) to six (6).

2. An LPN full-time with monthly documented RN supervision or an RN half-time who shall:
   - Do health assessment upon admission and ongoing assessment at least every 6 months
   - Dispense or supervise the dispensing of medication
   - Administer or oversee treatments
   - Maintain medical information for each participant including the admission exam, annual results of the TB test, and other relevant medical information
   - Record regular notes to include the following information:
     - Health status of participant upon admission and at least every six months
     - Date, time, dosage of medications and/or treatments as well as the person responsible for administration with appropriate doctor's orders
     - Any unusual symptoms, actions or appetite
   - Contacts with other health professionals concerning the participant

3. Personal care shall be provided by the nurse or personal care attendants

who are adult day services program assistants, certified nursing assistants, qualified medication aides, or home health aides.

- Personal care assistants will maintain all required continuing education requirements unique to their certification and will maintain current certificates.

4. A degreed social worker, certified therapist, or related professional is available if needed for monthly consultation and documentation regarding psychosocial needs of participants.

5. Those centers providing services to individuals with mild to moderate cognitive impairments must provide training to all staff involved with activities programming, and personal care staff in dementia specific care.

6. Discharge or transition summary by qualified staff.

Intensive (Level 3)

1. The staff and client ratio shall be a minimum of one (1) to four (4).

2. An LPN shall be on staff full-time with monthly documented RN supervision or an RN half-time who shall be available for all hours of the program and available to fulfill all duties as noted for nurses in the Basic (Level 1) and Enhanced (Level 2) levels. Additionally, an LPN or RN will provide more intensive nursing interventions as appropriate and/or prescribed such as colostomy care, tube feeding, injections, dressing changes, catheter care, blood sugar checks, etc.

3. There shall be full-time, qualified staff available to attend to the psychosocial needs of participants with monthly documented supervision by a licensed social worker, certified therapist, or related professional.

4. Activities staff will receive training in modification of therapeutic activities to meet the specialized need of moderate to severe cognitive impairments and/or higher physical acuity needs of participants.

FSSA Waiver Services or designee may grant an exception to the training requirements established in these Certification Standards for a staff member who holds a current Indiana license as a health care professional such as a physician, registered nurse, or licensed practical nurse. The requirement for maintaining CPR certification shall not be waived.

F. Required Documentation for Provider/Center Maintained Files

The Provider/Center must maintain a file that includes copies of all the documentation required for the Provider Enrollment and Certification process, as well as the documentation to substantiate that these requirements are maintained. These will

include, but are not limited to fire inspection, emergency plans and contact numbers, training certifications for all staff, Medicaid Provider Agreement, insurance documentation, and required health and safety records. In addition, the center will maintain current and comprehensive participant files (See section H. below).

The ADS provider shall have readily-available a copy of the address and telephone number of the local or state ombudsman program and of the local Area Agency on Aging.

The FSSA Division of Aging provider agreement, attached conditions to the agreement if applicable, the Consumer Rights, the floor plan that indicates the fire evacuation route, the Policies and Procedures, the FSSA Waiver Services or designee inspection form, Ombudsman Poster, calendar of available activities and menu, and the Division of Aging or designee procedures for making complaints shall be posted or made readily available to participant and others.

G. Admission Requirements

Prior to placement, the ADS center, with the assistance of the case manager, will meet with potential participants who are interested in attending ADS. The case manager may evaluate the participant's level of care prior to the participant meeting the ADS provider. The case manager's assessment of the participant's level of care and eligibility may then be faxed to the ADS provider with a recommendation. The provider makes the final decision as to whether the facility can meet the needs of a participant.

The provider must obtain and document general information regarding the participant. The information shall include names, addresses, and telephone numbers of relatives, significant persons, case managers, and medical/mental health providers. The record shall also include the date of admission, the participant's Social Security and/or RID number, medical insurance numbers, birth date, and hospital preference.

The provider shall also obtain and place in the record any medical information available including history of accidents, illnesses, impairments or mental status that may be pertinent to the participant's care. Additional histories including the following are encouraged, but not required: history of over the counter drug usage, social history.

The provider must ask for copies of the following documents and the provider must document whether or not the participant has them: Advance Directive, living will, power of attorney, health care representative, do not resuscitate order, letters of guardianship, or letters of conservatorship. The copies shall be placed and maintained in a prominent place in the participant file and sent with the participant when transferred for medical care.

Consumer or Participant Contract: Prior to admission, the ADS provider or center must complete a Consumer Contract with each potential participant or his/her designated representative. This contract is to be reviewed annually by provider, participant and/or participant caregivers. The center may use its own forms, but must contain the following topics:

- Name, street address, and mailing address of the ADS facility, and the term of the contract
- A description of the services to be provided to the participant
- A description of additional services provided outside of the Waiver program, but for which the center may assist in by arrangement of appointments or provision of transportation
- A description of the process through which the contract may be modified, amended, or terminated
- A description of the complaint resolution process available to the participants, and the name of the participant's designated representative, if applicable
- Specific information related to any Policies and Procedures, which must not be in conflict with the Consumer Rights as defined in these standards. A copy of the written Policies and Procedures shall always be accessible to the participant and is subject to review and approval by FSSA Waiver Services or designee prior to HCBS Medicaid Waiver Program enrollment
- A statement of consumer rights, to be signed by the provider and participant. The ADS provider shall provide a copy of Consumer Rights prior to execution of the consumer contract and provide a copy of the Consumer Rights to anyone requesting a copy

Participants shall not be liable for damages considered normal wear and tear. The ADS provider will not include any provision in a consumer agreement or disclosure statement that is in conflict with these rules, and shall not ask or require a participant to waive any of the consumer rights or the facility's liability for negligence. The provider will retain a copy of the signed and dated consumer agreement and provide copies to the participant or to his/her designated representative and to FSSA Waiver Services or designee upon request.

During the initial phase following the participant's admission, the provider shall continue the assessment process, which includes documenting the participant's preferences and observed or expressed care needs. The provider must promptly report significant changes in the participant's condition to the HCBS Medicaid Waiver case manager, participant and/or caregiver.

H. Comprehensive Participant Files

These files must include and maintain all prudent and obtainable personal information about participant, including but not limited to: name, date of birth, social security number and/or RID number, family contact, medical information, current Plan of Care from case manager, Individual Care Plan from center, and documentation of all reported incidents involving the health of the participant. Provider is to be aware and understand all privacy and HIPAA regulations concerning participant's records and information kept confidential except as may be necessary in the planning or provision of care or medical treatment, or related to an investigation or sanction action under these standards.

Personal files for HCBS Medicaid Waiver Program participants maintained by the provider shall be readily available at the ADS facility for all staff and to representatives of FSSA Waiver Services or designee conducting inspections or investigations, as well as to participants, their authorized representative or other legally authorized persons. The Ombudsman has access to all participant and facility files.

I. Level of Service and Payment

ADS will be provided and paid according to these three (3) levels of service, with level 1 being the least impaired and level 3 the most impaired/dependent. The upper threshold for ADS provision does not include any Nursing Facility level of care above Level 3, or the skilled level of care as defined in 405 IAC 1-3-1.

The Adult Day Services- Levels of Service Assessment tool will be based on the point system definitions designated on the Level of Service Assessment Tool. A provider or center may request a change in level of service for a participant at any time during the year, but must specify the request, and the reason it is desired, in writing. Assessment will be completed when there have been significant changes in condition.

ADS may provide services to those participants who are determined to meet any of the three care levels, and whose needs can be met in an ADS setting. Providers may only admit or continue to care for participants whose impairment levels are within the classification level of the facility.

A participant may move from one level of service to another level (as determined by the Levels of Service Assessment) with the same provider. When there is need to change the Level of Service or a provider, an updated Plan of Care/Cost Comparison Budget will be submitted. It is the case manager's responsibility to assure the Plan of Care/Comparison Budget reflects the appropriate level of service that meets the needs of the participant in an efficient and effective manner.

Some items may become disqualifiers for admission. (For example, if the facility is unable to provide a safe environment for a participant who is an unpredictable elopement risk, etc.) Levels of Service will be designated as Levels 1, 2, or 3.

The ADS Levels of Service Assessment Tool will assess consumer's Level of Service needs based on a point system:

Level 1-Total points 1-11
Level 2-Total points 12-21
Level 3-Total points 22-36+

Following approval of ADS services and admission to an ADS facility, the case manager shall conduct and document a review of the participant's status on-site at least once every ninety (90) days. Reassessment will occur more frequently as needed as determined by the case manager, caregiver and/or provider. The Level of Service

Assessment will be completed and documented as often as necessary, and at minimum, as part of the annual level of care eligibility re-determination process.

J. Care and Service Standards

The ADS provider must have the ability to provide services for participants in a manner and in an environment that encourages maintenance or enhancement of each participant's quality of life, and promotes the participant's dignity, choice, independence, individuality, and decision-making ability. The ADS center, with the assistance of the case manager and participant, must create and make readily accessible to the participant and caregiver a calendar which will include scheduled activities with the understanding that it is subject to change based on participant's choice. ADS providers shall make available activities each week that are of interest to the participants. Activities shall be oriented to individual preferences as indicated in the participant's care plan.

Any services performed under the HCBS Medicaid Waiver Programs for persons who are aged or medically disabled must comply with the prohibitions regarding the practice of medicine under IC 25-22.5-1.

Medications, Treatments and Therapies:

1. The direct care staff shall demonstrate an understanding of each participant's medication administration regimen, including the reason for which the medication is used, medication actions, specific instructions and common side effects. All medications should be kept locked in cabinet in the facility. Participants should not be allowed to keep medications on their person while in the facility.

2. The provider shall obtain and place a written, signed order in the participant's record for any medications that have been prescribed by the physician/nurse practitioner. Orders must be carried out as prescribed unless the participant or their legal representative refuses to consent. Changes may not be made without a physician/nurse practitioner's order and the physician/nurse practitioner must be notified if a participant refuses to consent to an order. Order changes obtained by telephone must be documented by filing the pharmacy receipt detailing specifics regarding the prescription. Over-the-counter medication requested by the participant must be addressed in the plan of care, and must be reviewed by the participant's physician, nurse practitioner, or pharmacist as part of developing the care plan and at time of care plan review.

3. For prescription medications ordered by a physician, nurse practitioner, or pharmacist to be given "as needed" or "p.r.n.", orders must be followed exactly as they are written; specifically when, how much and how often it may be administered.

4. Self-medication: Participants must have a physician/nurse practitioner's written order of approval to self-medicate. Each participant's medication container will be clearly labeled with the pharmacist's label or be in the original labeled container or bubble pack. All staff must have ready access to the participant's medications and be able to access them per the participant's request, but participants must not have access to other participant's medications. Over-the-counter medications in stock bottles (with original labels) may be used.

5. For some participants, it will be necessary that the staff oversees their medicine intake. With participants who require this level of assistance with their medication, a current, written medication administration record shall be kept for each participant and shall identify all of the medications administered by the staff to the participant, including over-the-counter medications and prescribed dietary supplements. The document record will indicate the medication name, dosage, route (if other than oral), and the date and time to be given. It will also include a signature of staff member providing assistance.

6. A discontinued or changed medication order will be marked and dated on the medication administration record as discontinued. The new order will be written on a new line showing the date of order. If a participant misses or refuses a medication, treatment or therapy the initials must be circled and a brief but complete explanation must be recorded on the back of the medication record. As needed (p.r.n.) medication shall be documented with the time, dose, the reason the medication was given, and the outcome.

The participant shall be free from chemical restraint at all times. Physical restraint is not allowed in an ADS facility. If participant loss of control warrants this level of restraint, staff should call for emergency assistance.

In the event of a serious medical emergency, staff will call 911 or the appropriate emergency number for their community. The family or representative and the case manager (when applicable) shall also be called. The provider will have copies of Advance Directives, Do Not Resuscitate (DNR) orders and/or pertinent medical information available when emergency personnel arrive.

Participant Discharges:

1. A participant may not be involuntarily discharged without a 30 day written notice to the participant regarding the discharge. The notification should be provided on a form prescribed by FSSA Division of Aging, to the HCBS Medicaid Waiver case manager, the participant's legal representative, guardian, and the ombudsman. The notice shall state the reasons for the discharge and the participant's right to object to the discharge. A participant that is to be involuntarily discharged may appeal the

determination under 405 IAC 1.1.

2. Exceptions include situations in which undue delay might jeopardize the health, safety or well-being of the participant or others, and are outlined in the Aging Rule and FSSA Division of Aging Provider Agreement.

3. Participants may be discharged involuntarily without the 30 day notice from the ADS provider only the following reasons:
    - Medical emergencies
    - Behavior which poses an imminent danger or harm to self, others or staff
    - Loss of eligibility for the HCBS Medicaid Waiver Program
    - The participant's care needs exceed the ability or classification of the ADS provider
    - The ADS Provider has had the HCBS Medicaid Waiver Provider Agreement revoked, not renewed, or voluntarily surrendered

If the participant has a medical emergency and/or needs to be admitted to a hospital, the ADS provider must notify the participant's case manager and caregiver as soon as reasonable in order to make the necessary arrangements for the provision of on-going care.

III. Participant Eligibility Requirements

A. Medical and Financial

The FSSA Waiver Services will determine participant eligibility based on the determination that the participant meets Nursing Facility Level of Care (LOC), as well as Medicaid Requirements. Participants who are eighteen years of age or older and are eligible and approved for the A&D Waiver may be eligible for this service.

B. Assessment Tool for Participant Screening

Participants who seek ADS as a service through the FSSA Waiver Services Medicaid Waiver Program must contact the local Area Agency on Aging to complete the Waiver application. A case manager will be assigned and will complete an eligibility assessment, which will determine if the participant requires a level of care provided by a nursing facility as found at 405 IAC 1-3-1 and 1-3-2. The nursing facility level of care eligibility assessment shall be conducted prior to the start of the HCBS Medicaid Waiver and at least annually thereafter.

Prior to the start of ADS, the Case manager will complete an Adult Day Service Level of Service Assessment. The Level of Service Assessment Tool shall assess the participant's needs in multiple areas. Once complete, a copy of the Level of Service Assessment document will be given to the prospective participant or his/her

representative, and a copy will be placed in the participant file should the prospective participant begin ADS.

C. Consumer/Participant Rights

The ADS provider must respect all rights recognized by law with respect to discrimination, service decisions (including the right to refuse services), freedom from abuse and neglect, privacy, association, and other areas of fundamental rights.

Every participant receiving services in the ADS facility may contact their local or state ombudsman if they have concerns about the provision of this service. The provider is obligated to make available to the participant the contact information for the ombudsman.

ADS providers must accord the participants attending their facility the basic rights enjoyed by all individuals in this state, including but not limited to: freedom from verbal, sexual, physical, emotional**,** financial and mental abuse; freedom from physical or chemical restraints for the purposes of discipline or convenience, and not required to treat the participant's medical symptoms; freedom to have records kept confidential and released only with a participant's consent consistent with state law; and freedom to have a service animal, consistent with the "reasonable accommodations" clause of the Fair Housing Act.

IV. Case Management Responsibilities

The case manager will make level of care determinations for all applicants for this service. This process will utilize the Eligibility Screen. The 450B Physician Certification for Long Term Care Services must be completed for initial application.

A Plan of Care will be developed by the case manager with input from the consumer/guardian and the provider. This Plan of Care will describe the medical and other services (regardless of funding source) to be furnished, their frequency, and the type of provider who will furnish each. All services will be furnished pursuant to a written Plan of Care/Cost Comparison Budget. The Plan of Care/Cost Comparison Budget will be subject to the approval of the FSSA Waiver Services Waiver Specialists. Based on the assessment and the authorized plan of care, the Individual care plan for the center will be completed and documented within the initial fourteen (14) day period.

The Individual Care Plan shall:

- support the principles of dignity, privacy, and choice in decision-making, individuality, and independence
- describe the participant's capabilities, needs and preferences, and shall define the division of responsibility in the implementation of services
- address, at a minimum, the following elements: assessed health care needs; social needs and preferences; personal care tasks;

and if applicable, limited nursing and medication services, including frequency of service and level of assistance

- be reviewed by the HCBS Medicaid Waiver case manager, and updated at least every ninety (90) days; and more often as the participant's condition changes or as determined by the case manager, provider or participant
- be updated when there are changes in the services the participant needs and wants to receive
- be cost neutral (as defined in Waiver manual)

A review note with the date and reviewer's signature shall be documented in the record at the time of the review. If the Individual Plan of Care contains many changes and becomes less legible, a new Individual Plan of Care shall be written.

The HCBS Medicaid Waiver case manager shall provide the participant, the provider, and Area Agency on Aging with a copy of the plan of care, and the provider shall place a copy in the participant's file.

Annual Reassessments and Development of Annual Plan of Care/Cost Comparison Budget: Each participant's Plan of Care/Cost Comparison Budget will remain in effect for a period not to exceed 12 months. The annual Plan of Care/Cost Comparison Budget will be cooperatively developed by the case manager, the participant/guardian and provider. The Plan of Care/Cost Comparison Budget must be submitted via the current State approved electronic data base, to the State Waiver Unit for review at least 6 weeks prior to expiration of current Plan but no earlier than 2 months prior to expiration of current Plan. A new Level of Care Assessment must be completed as well as a new Levels of Service Assessment.

All documentation by case manager must be entered in the current state approved electronic database.

The case manager must assure that each participant is given the free choice of all qualified providers, including case managers. The participant must sign the Freedom of Choice form. This must be documented in the State approved electronic database.

V. Quality Assessment and Provider Compliance

A. Monitoring for Quality Assurance

FSSA Waiver Services or designee shall conduct an inspection of the ADS facility prior to issuance of a HCBS Medicaid Waiver Provider Agreement, and will conduct an announced or unannounced inspection annually.

Inspection may also take place upon receipt of an oral or written complaint of violations that threaten the health, safety, or welfare of participants; or anytime FSSA Waiver Services or designee has reason to believe a facility has violated a condition or HCBS Medicaid Waiver standard, or is operating waiver services without a HCBS Medicaid

Waiver Provider Agreement and billing number. Inspections may also take place for the purpose of routine monitoring of the participant's care. Once an on site review has taken place, another inspection may be necessary to determine if cited deficiencies have been corrected. Mini inspections will also be completed during case manager visits, with completion of health and safety indicator checklist to identify any concerns.

State or local fire inspectors shall be permitted access to enter and inspect ADS facilities regarding fire safety upon request of FSSA Waiver Services or designee.

FSSA Waiver Services or designee shall have full access and authority to examine and copy ADS facility and participant records. Copies may be requested and arrangements to make these copies will be the responsibility of the provider. The copying of these records must be done in a manner that is compliant with HIPAA Rules. FSSA Waiver Services or designee will also have access to inspect the physical premises, including the buildings, grounds, equipment and any vehicles relating to HCBS Medicaid Waiver Program participation and complaint investigations in the ADS facility.

FSSA Waiver Services or designee has authority to interview the provider, primary caregiver, substitute caregivers, staff and participants. Interviews shall be confidential and conducted privately.

Providers must authorize staff members to permit entrance by the FSSA Waiver Services or designee for the purpose of inspection, investigation, and other duties within the scope of their authority.

FSSA Waiver Services or designee has authority to conduct inspections with or without advance notice to the provider, staff, or a consumer of the facility. FSSA Waiver Services or designee shall not give advance notice of any inspection if they believe that notice might obstruct or seriously diminish the effectiveness of the inspection or enforcement of these Certification Standards.

Inspectors will respect the private possessions of participants, providers and staff while conducting an inspection.

The Ombudsman has the right to enter the facility at the request of the participant, providing any additional quality oversight.

B. Incident Reporting

FSSA Waiver Services or designee shall furnish each ADS facility with information on how a participant can submit a complaint. This information must be kept in a conspicuous, readily accessible place and which states the telephone number at the state to which incidents must be reported. It will also list the Ombudsman and the procedure for making complaints.

Incident Reporting within the Waiver Process: Based on the Aging Rule, any unusual occurrence will require an Incident Report to be completed by the provider and/or the

case manager. Unusual occurrences include but are not limited to any of the following: abuse, neglect, un-explained injuries, death, etc.

The process for filing an Incident Report includes the following:

1. Incident is identified
2. Reporting entity reports the incident using the prescribed process (i.e. web reporting system). The report includes a detailed explanation as to what happened, when, how it happened, action taken after the incident, etc
3. Bureau of Quality Improvement Services (BQIS) will review the incident and assign the appropriate coding (abuse, neglect, sentinel status etc)
4. BQIS will e-mail the incident report information to the case manager
5. The case manager will follow up to ensure the health and safety is in place for the individual. The case manager will follow up every seven days until the incident is resolved

FSSA Waiver Services, BQIS, or designee and the case manager will work with the ombudsman and adult protective services to investigate and act on suspected abuse or exploitation immediately and to follow up on other complaints or concerns as quickly as possible. Incident Reports will be followed per the guidelines outlined above. The primary purpose of the prompt response is to protect the participant and correct the situation. Investigations of complaints alleging injury, abuse or neglect shall be completed as soon as possible and in accordance with complaint standards utilized by the ombudsman program and adult protective services.

The ADS provider shall not retaliate in any way against any participant after the participant or someone acting on his/her behalf has filed a complaint, been interviewed, or served as a witness, and must ensure that all staff follow the Incident Reporting procedures.

C. Procedures for Corrections of Violations

If, as a result of an inspection or investigation, FSSA Waiver Services or designee determines that abuse has occurred, the provider shall be notified verbally to immediately cease the abusive act. The incident will be reported though the above guidelines and will be reported to Adult Protective Services. Arrangements will be made for immediate relocation of the participant, and the provider's enrollment in the HCBS Medicaid Waiver Program will be terminated.

If an inspection or investigation indicates a violation of the Certification Standards other than abuse, FSSA Waiver Services or designee shall notify the provider in writing of violations of these Certification Standards.

FSSA Waiver Services may require the provider to develop a corrective action plan that will be approved by BQIS/Division of Aging.

The provider shall notify BQIS/Division of Aging of correction of violations no later than the date specified in the notice of violation.

FSSA Waiver Services or Designee shall conduct a re-inspection of the facility after the date that the FSSA Waiver Services receives the report of compliance or after the date by which violations must be corrected as specified in the notice of violation.

For violations that present an imminent danger to the health, safety or welfare of participants, the HCBS Medicaid Waiver Provider Agreement may be immediately suspended and arrangements made to move the participants.

If, after inspection of a facility, the violations have not been corrected by the date specified in the notice of violation or if FSSA Waiver Services, BQIS, or designee has not received a report of compliance from provider, FSSA Waiver Services or designee shall terminate the HCBS Medicaid Waiver Provider Agreement.

D. Disenrollment of Provider

FSSA Waiver Services or designee shall deny, suspend or revoke HCBS Medicaid Waiver Program enrollment if a provider, staff member or other person who has unsupervised access to participants in the adult day service facility, has been:

1. Convicted of a crime against a person;
2. Convicted of a crime relating to financial exploitation;
3. Found by a court in a protection proceeding; to have abused or financially exploited a vulnerable adult;
4. Obtained or attempted to obtain HCBS Medicaid Waiver Program enrollment by fraudulent means or misrepresentation;
5. Permitted, aided, or abetted the commission of any illegal act on the ADS facility premises;
6. Been convicted of a felony or a crime against a person if the conviction reasonably relates to the competency of the person to own or operate an ADS facility;
7. Been convicted of the illegal use of drugs or the excessive use of alcohol within the past five years without evidence of rehabilitation;
8. Been convicted of the illegal selling or distribution of drugs;
9. Been convicted of any crime involving a firearm used in the commission of a felony or in an act of violence against a person;
10. Refused to permit authorized OMPP representatives to interview participants or have access to participant records;
11. Interfered with an Ombudsman, an adult protective services investigator, a HCBS Medicaid Waiver case manager, or any person or entity from an area agency on aging or the OMPP in the performance of quality assurance and consumer protection activities on behalf of a citizen in the performance of official duties; and/or
12. Been found by the court in a proceeding to have committed an act of domestic violence toward a family or household member;
13. Has been reported to operate with unsafe conditions.

Failure of a provider to follow a participant's Plan of Care, or any provisions of these Certification Standards, or failure by a provider to comply with the Consumer Rights

established under any of the HCBS Medicaid Waiver Programs, is considered a willful violation of the HCBS Medicaid Waiver Programs and subject to disenrollment.

A provider whose HCBS Medicaid Waiver Provider Agreement has been revoked, voluntarily surrendered during a revocation/non-renewal process, or whose application has been denied shall not be permitted to re-enroll in the HCBS Medicaid Waiver Program for one year from the date the revocation, surrender, or denial is final, or for a longer period if specified in the order revoking or denying the enrollment.

FSSA Waiver Services shall deny, revoke, or refuse to renew the HCBS Medicaid Waiver Provider Agreement where it finds there has been substantial non-compliance with these standards or where there is substantial non-compliance with local codes and ordinances or any other state or federal law or rule applicable to the health and safety of caring for participants in an Adult Day Service facility.

VI. Transportation

Transportation services can be provided for Adult Day Services under the Aged and Disabled Waiver. There is a rate specific to transportation for ADS providers. If the ADS provider plans on providing transportation or subcontracting out transportation services, the provider will need to check “ADS transportation” on the Aged and Disabled Waiver Application.

Any questions concerning the standards and guidelines for Adult Day Services can be addressed to FSSA, Division of Aging at 800-545-7763.

Indiana Family and Social Services Administration
Division of Aging
Approval Request For
Providers of Adult Day Services

The Indiana Family and Social Services Administration Medicaid Waiver Program is responsible for approval of providers for Adult Day Services under Medicaid Home and Community–Based Services administered by the Division of Aging.

The attached Service Definition, Medicaid Waiver Standards and Guidelines, Level of Assessment/Evaluation, and the Indiana Adult Day Service Survey Tool are used in this process. To apply for approval, please complete the enclosed survey tool. Return the tool and all documentation requested to:

Linda Wolcott, Waiver Operations
MS 21 Division of Aging
402 W. Washington Street, Room W454
P.O. Box 7083
Indianapolis, IN 46207-7083

When your facility is fully operational and is in compliance with all of the requirements in this survey, an on-site inspection will be scheduled to survey the adult day services facility, meal preparation area (if applicable), and the facility's records: personnel and participants.

Any approval granted by FSSA upon review of such application and inspection shall be for the purpose of enrollment in one or more of the home and community-based services programs administered by the Division of Aging. It shall be limited to the specific services for which approval is sought, and shall be subject to the provider's execution of a Provider Agreement with the Office of Medicaid Policy and Planning (for Medicaid waivers) or a contract with the appropriate Area Agency on Aging (for other funding programs). The facility will abide by all terms and conditions of such Provider Agreement and/or contract.

Provider Name:_____

Address:_____City: _____Zip:_____

Contact Person:_____Telephone:_____

Definition of Adult Day Services

Adult Day Services (ADS) are community based group programs designed to meet the needs of adults with impairments through individual plans of care. These structured, comprehensive, non-residential programs provide a variety of health, social, recreational and therapeutic activities, supervision, support services, and in some cases personal care. Meals and/or nutritious snacks are required. The meals cannot constitute the full daily nutritional regimen. Each meal must meet 1/3 of the Dietary Reference Intake. These services must be provided in a congregate, protective setting. By supporting families and other caregivers, adult day services enable participants to live in the community. Adult Day Services assess the needs of participants and offer services to meet those needs. Participants attend on a planned basis. There is no longer a minimum number of hours required, but there is a cap of ten (10) hours per day. There are three levels of adult day services: Basic, Enhanced, and Intensive.

1. Basic Adult Day Service (Level 1) includes:

a. Monitor and/or supervise all Activities of Daily Living (ADL's are defined as dressing, bathing, grooming, eating, walking, and toileting) with hands on assistance provided as needed
b. Comprehensive, therapeutic activities
c. Assure health assessment and intermittent monitoring of health status
d. Monitor medication / or medication administration
e. Ability to provide appropriate structure and supervision for those with mild cognitive impairment.
f. Staff to Participant ratio not to exceed 1:8

2. Enhanced Adult Day Service (Level 2) includes:

Basic (Level 1) service requirements must be met.

Additionally:

a. Provide hands-on assistance with 2 or more ADL's or hands-on assistance with bathing or other personal care
b. Health assessment with regular monitoring or intervention with health status
c. Dispense or supervise the dispensing of medications to participants
d. Psychosocial needs assessed and addressed including counseling as needed for participants and caregivers
e. Ability to provide therapeutic structure, supervision and intervention for those with mild to moderate cognitive impairments.
f. Staff to Participant ratio not to exceed 1:6

3. Intensive Adult Day Service (Level 3) includes:

Basic (Level 1) and Enhanced (Level 2) service requirements must be met.

Additionally:

a. Hands on assistance or supervision with all ADL's and personal care
b. One or more direct health intervention(s) required
c. Rehabilitation and restorative services including Physical Therapy, Speech Therapy, Occupational Therapies coordinated or available
d. Ability to provide therapeutic intervention to address dynamic psychosocial needs such as depression or family issues effecting care
e. Ability to provide therapeutic interventions for those with person with moderate to severe cognitive impairments
e. Staff to Participant ratio not to exceed 1:4

Adult Day Service Requirement	Met	Not Met	Planned Date of Compliance	Verified Compliance	Comments/Notes
I. Provider Eligibility and Enrollment					
A. Legal Entity- Is the ADS provider a recognized legal entity authorized to do business in the State of Indiana?					
B. Provider enrollment application is complete including documentation of:					
1. The maximum consumer capacity requested.					
2. The service level classification being requested					
3. A floor plan of the facility showing exits, wheelchair ramps if applicable, smoke detectors and extinguishers. The floor plan shall show exits and directions for vacating the premises.					
4. A written plan describing the Policies and Procedures including the planned operation of the ADS, use of direct care staff, indirect care staff, and the use of substitute staff (i.e. volunteers)..					
II. Certification of ADS Provider Facility					
A. On-site provider files that document that all provider requirements are met (i.e.: liability insurance, current initial physical exam, etc.) are present, and available for review by inspector.					
B. All applicable local zoning, building codes and state and local fire and safety regulations for a public facility are met.					
C. The building and furnishings are clean and in good repair and grounds are well maintained.					
D. Physical Requirements:					

Adult Day Service Requirement	Met	Not Met	Planned Date of Compliance	Verified Compliance	Comments/Notes
1. Does the facility provide at least 40 square feet of indoor space per client, excluding hallways, offices, restrooms, and storage room?					
2. Is there appropriate space for rest, therapies, personal care and/or to isolate the ill?					
3. Is the furniture and equipment safe, comfortable and designed appropriately for use by persons with physical disabilities?					
4. Is there adequate illumination, sound transmission, heating, cooling, ventilation, and maintenance to facilitate comfortable and safe conditions?					
5. Does the facility have approval for use by the State Fire Marshal's office with the inspection by local fire department on file?					
6. Is the facility approved for use and inspected by the Indiana Department of Health with inspections kept on file?					
7. Do the physical facilities conform with the American with Disabilities Act Accessibility Guidelines from the Americans with Disabilities Act of 1990, accommodating disabled individuals, And include the following:					
a. Is designated parking available and easily accessible, with marked parking areas?					
b. Do sidewalks consist of continuous, uninterrupted surface made of firm,					

Adult Day Service Requirement	Met	Not Met	Planned Date of Compliance	Verified Compliance	Comments/Notes
non-slip materials?					
c. Do ramps (exterior and interior) have a maximum gradient of 1 foot rise in 12 feet, with handrails 34-38" high and extending 12" beyond the ramp. All ramps have a non-slip surface?					
d. Does entrance have a level approach platform?					
e. Is entrance door is 32" wide?					
f. Is entrance threshold flush or bi-level with no more than 1" lip?					
g. Are floor materials non-slip?					
h. Do stairs have handrails 34-38" high?					
i. Is there at least 1 toilet for every 10 persons served?					
j. Are toilet facilities floor level with corridor, and at least one compartment has two (2) 36" high grab bars?					
k. Toilet compartment must have (36) inch wide out swinging door.					
8. If the adult day service program is co-located with other services in a facility, does the day center have its own separate identifiable space?					
9. There is no accumulation of garbage, debris, rubbish, or offensive odors.					
10. All passageways are unobstructed throughout the facility, and hallways are wide enough to accommodate a wheelchair or walker.					
E. Safety Requirements:					
1. At least one working fire extinguisher is in					

Adult Day Service Requirement	Met	Not Met	Planned Date of Compliance	Verified Compliance	Comments/Notes
a visible and readily accessible location on each floor, including basements, and shall be inspected at least once a year.					
2. Fire extinguishers shall be tagged, with a signature and date of inspection.					
3. There are readily available basic first-aid supplies and a first-aid manual.					
4. Smoke detectors are installed in accordance with the manufacturer's listing in hallways or access areas where participants congregate, any interior Designated smoking area, in basements, and, in two-story facilities, smoke detectors are installed at the top of the stairway to the second floor.					
5. Detectors are equipped with a device that warns of low battery when battery operated or with a battery backup if hard wired					
6. Battery-operated smoke detectors are tested monthly and batteries changed at least once per year.					
7. All exit doors and interior doors have simple hardware that cannot be locked against exit without an obvious method of operation, and which does not require a key when locked against exit. (i.e. key pad lock)					
8. A public water supply is utilized if available. If a non-municipal water source is used, minimum water quality standards must be met.					

Adult Day Service Requirement	Met	Not Met	Planned Date of Compliance	Verified Compliance	Comments/Notes
9. Septic tanks or other non-municipal sewage disposal system are in good working order.					
10. Incontinence garments are disposed of in closed containers, if applicable.					
11. Garbage and refuse are suitably stored in clean, rodent-proof, covered containers, pending weekly removal.					
12. Sanitation for pets and other domestic animals is adequate to prevent health hazards.					
13. Proof of rabies or other vaccinations required by a certified veterinarian are maintained on the premises for household pets.					
14. Pets not confined in enclosures are under control and do not present a danger to participants or guests.					
15. Flammable and combustible liquids and hazardous materials are safely and properly stored in original, properly labeled containers or safety containers and secured in areas to prevent tampering by consumers or vandals.					
16. Cleaning supplies, poisons and insecticides are properly stored in original, properly labeled containers in a safe area away from food preparation and storage areas, dining areas, and medications.					
17. Universal precautions for infection control are followed in consumer care. Hands					

Adult Day Service Requirement	Met	Not Met	Planned Date of Compliance	Verified Compliance	Comments/Notes
and other skin surfaces are washed immediately and thoroughly if contaminated with blood or other body fluids.					
F. Bathroom specifications:					
1. Consumer's bathroom provides individual privacy and has a finished interior, with a mirror; a functioning window or other means of ventilation; and a window covering.					
2. The room is clean and free of objectionable odors. There are tubs or showers, toilets and sinks in good repair.					
3. Bathrooms have hot and cold water at each tub, shower, and sink in sufficient supply to meet the needs of the participants.					
4. Hot water temperature in bathing areas is supervised for persons unable to regulate water temperature.					
5. Shower curtains and doors are clean and in good condition.					
6. Non-slip floor surfaces shall be provided in tubs and showers.					
7. Safe and secure grab bars for toilets, tubs, and/or showers are installed for participant's safety.					
8. Adequate supplies of toilet paper and soap are available.					
G. Meal Specifications:					
1. Nutritious meals must be offered daily and equal 1/3 of the Dietary Reference					

Adult Day Service Requirement	Met	Not Met	Planned Date of Compliance	Verified Compliance	Comments/Notes
Intake.					
2. Nutritious snacks and liquids are available and offered to fulfill each participant's nutritional requirements.					
3. Special consideration is given to participants with chewing difficulties and other eating limitations.					
4. Special diets are followed as prescribed in writing by the participant's physician/nurse practitioner.					
5. Food is stored and maintained at the correct temperature in a properly functioning refrigerator.					
6. Utensils, dishes and glassware are washed by dishwasher or by hand in hot soapy water, rinsed, and stored to prevent contamination.					
H. Consumer Risk Contract:					
1. The provider has initiated a Consumer Risk Management Contract for each consumer.					
I. Fire and Emergency Evacuation Requirements:					
1. An emergency evacuation plan has been developed, posted and rehearsed on a quarterly basis with participants and staff.					
2. All staff are required to demonstrate the ability to quickly evacuate all participants from the facility to the closest point of safety, which is exterior to, and away from the structure.					
3. A floor plan containing fire exits,					

Adult Day Service Requirement	Met	Not Met	Planned Date of Compliance	Verified Compliance	Comments/Notes
evacuation routes, smoke detectors and fire extinguishers is posted.					
4. There is a second safe means of egress.					
5. There is at least one flashlight available on each floor for emergency lighting that is checked on a monthly basis.					
6. Smoking policies					
a. Smoking is allowed only in designated areas.					
b. Smoking is prohibited in areas where oxygen is used.					
c. Ashtrays of noncombustible material and safe design are provided in areas where smoking is permitted.					
III. Staff Requirements					
A. If the ADS is housed in a building with other services or programs, or is part of a larger organization, there is a separate identifiable staff available during operational hours.					
B. Training Requirements for all Staff:					
1. At least 18 years of age.					
2. Had a physical exam and a TB test which have been signed by a physician or nurse practitioner and placed in employee personnel files?					
3. Passed a criminal record check.					
4. Are literate and can demonstrate the understanding of written and oral orders.					
5. Is there a staff person appointed by the Administrator or Program Director to supervise the ADS in the absence of the Director?					

Adult Day Service Requirement	Met	Not Met	Planned Date of Compliance	Verified Compliance	Comments/Notes
6. Is there documentation that all staff received orientation prior to providing services, including policies and procedures, participants' rights, evacuation procedures, location of participants' records, emergency contact numbers, and location of medication cabinet and key.					
C. Does **Level One** staff training and documentation include the following:					
1. Basic first aid					
2. CPR certification					
3. Training on emergency procedures, implementation, and responsibilities including fire and safety procedures.					
4. Observation, documentation, and communication skills.					
5. Working with older persons and/or persons with disabilities.					
6. Aging process, including normal psychological, social, and physiological changes of aging.					
7. Basic information concerning medical treatments, age-related diseases, illnesses, drug interactions, medical terms, functional and behavioral issues, nutritional and end of life issues.					
8. Service plan development and implementation to maximize independence and prevent secondary impairments.					
9. Regular (at least quarterly) in-service					

Adult Day Service Requirement	Met	Not Met	Planned Date of Compliance	Verified Compliance	Comments/Notes
training which meets individual needs and enhances job performance.					
10. Training in recognizing abuse, neglect and exploitation and reporting procedures.					
11. Training on universal precautions.					
12. Training on cognitive impairments or special needs of populations served.					
13. Proper food handling and food safety training.					
D. Does **Level Two** staff training and documentation include the following:					
1. All of basic level one requirements.					
2. Are personal care services delivered by a certified program assistant, CNA, QMA, LPN or RN?					
3. Are certification requirements maintained and documented?					
4. Is administrative staff used in participant/staff ratio? If so, do they meet same training requirements?					
E. Does **Level Three** staff training and documentation include the following:					
1. Does it include all the basic level I and enhanced level II requirements?					
2. Is there documentation of in-service for special needs of target populations?					
a. Are there procedures for 2 person transfer and personal care?					
b. Techniques to handle cognitive impairments with high risk of elopement.					

Adult Day Service Requirement	Met	Not Met	Planned Date of Compliance	Verified Compliance	Comments/Notes
c. Skills to assist with dining safety and choking prevention.					
d. Vital sign monitoring appropriate to disease diagnosis.					
F. Level Specific Staffing Requirements:					
1. **Basic (Level 1):**					
a. Is there a client/staff ratio no more than 8 clients per 1 staff ?					
b. Are volunteers included in the staff ratio? If so, are they professionally trained/certified/oriented as staff? (documentation available?)					
c. Is an RN or LPN available as a consultant for health needs, assessments, medications oversight or administration, health promotion, prevention of illness and health screening?					
d. Does staff that provides or assists with activities receive additional training in leading therapeutic group activities that meet the needs of the person served and maximize independence?					
2. **Enhanced (Level 2):**					
a. Is minimum staff/client ratio 1 to 6?					
b. Is there an LPN full-time with documented RN supervision or RN half-time?					
c. Do participants have a health assessment on admission & at least every 6 months?					

Adult Day Service Requirement	Met	Not Met	Planned Date of Compliance	Verified Compliance	Comments/Notes
d. Does LPN or RN dispense or supervise dispensing medication?					
e. Does LPN or RN administer or oversee treatments?					
f. Does LPN/RN have on file & updated yearly doctor's orders and information on participants? (diagnosis, history & physical, TB test/updated yearly)?					
g. Are there consistent nursing notes in the progress notes which indicate health status, medications, any unusual symptoms or actions, and medical contacts?					
h. Is personal care provided by appropriate staff (Certified Program Assistants, CNAs, LPNs, etc.)?					
i. Is there a degreed social worker available on staff or as consultant?					
j. If providing care to participant with mild to moderate cognitive impairments or dementia, does staff have appropriate in-services and education?					
k. Is discharge or transition summary completed on all discharged participants?					
3. **Intensive (Level 3):**					
a. Is minimum staff ratio 1 to 4?					
b. Is there an LPN full-time with RN documented oversight or RN half-					

Adult Day Service Requirement	Met	Not Met	Planned Date of Compliance	Verified Compliance	Comments/Notes
time, but available for all hours of program?					
c. Does RN or LPN fulfill all duties level I and II as well as Level III?					
d. Does nursing staff provide more intensive nursing intervention (e.g. colostomy care, dressing change) as appropriate?					
e. Is there full-time, qualified staff available to attend to the psychosocial needs of participants with monthly documented supervision by a licensed professional?					
f. Does activities staff have training in modification of therapeutic activities to meet specialized needs of target population (higher physical acuity needs, dementia) served?					
IV. Required Documentation for Provider Maintained Files:					
A. Must have documentation of:					
1. Fire inspection.					
2. Emergency plans and contact numbers.					
3. Training certifications for all staff.					
4. Medicaid Provider Agreement.					
5. Insurance documentation.					
6. Required health and safety records.					
B. Must have readily available a copy of address and phone number of local or state Ombudsman program and of the					

Adult Day Service Requirement	Met	Not Met	Planned Date of Compliance	Verified Compliance	Comments/Notes
local Area Agency on Aging.					
C. Must have readily available or posted the Policies and Procedures, FSSA Waiver inspection form, and procedures for making complaints.					
D. Admission Requirements and Documentation:					
1. Provider must obtain from participant:					
a. General information such as full name, addresses, birth date, SSN or RID number, medical insurance numbers, hospital preference, phone numbers for family members, physicians, case manager, etc.					
b. Medical information including history of accidents, illnesses, impairments or mental status.					
c. Provider must ask for copies of the following and document whether participant has them: Advance Directive, Living Will, DNR order, Letters of Guardianship, Designated Power of Attorney, or Letters of Conservatorship.					
2. Prior to admission, the provider must complete a Consumer Contract with each participant including the following information:					
a. Name, street, mailing address of facility, and term of contract.					
b. Description of services to be					

Adult Day Service Requirement	Met	Not Met	Planned Date of Compliance	Verified Compliance	Comments/Notes
provided to participant					
c. Description of additional services provided outside of the waiver program.					
d. Description of the process through which the contract may be modified, amended, or terminated.					
e. Description of the complaint resolution process.					
f. Information on access to Policies and Procedures for participant.					
g. A statement of consumer rights to be signed by the provider and participant. The consumer and/or designated representative, if applicable, are provided copies of the signed contract					
E. Comprehensive Participant Files: On-site personal files exist for each consumer including all prudent and obtainable personal information about consumer, including, but not limited to the following:					
1. Name.					
2. Date of Birth.					
3. Social Security Number or RID number.					
4. Family Contact.					
5. Medical Information					
6. Current Plan of Care.					
7. Legal Documents if established					
a. Guardianship					
b. Power of Attorney					
c. Healthcare Representative					

Adult Day Service Requirement	Met	Not Met	Planned Date of Compliance	Verified Compliance	Comments/Notes
d. Living Will Documents					
8. Incident Reports involving health and safety.					
9. Provider is aware and understands all privacy and HIPAA regulations concerning participant's records and information					
V. Care and Service Standards:					
A. A calendar exists and is readily accessible for the participant and staff that includes scheduled activities, all medical appointments and other services, and medication chart, if indicated.					
B. Medications, Treatments and Therapies: The provider and direct care staff should demonstrate an understanding of each participant's medication administration regimen, including the reason for the medication is used, medication actions, specific instructions and common side effects.					
. 1. Written, signed orders are in the participant's record for any medications prescribed by the physician/ nurse practitioner.					
2. Order changes obtained by telephone are documented by filing the pharmacy receipt detailing specifics regarding the prescription.					
3. Over-the-counter medication requested by the participant is					

Adult Day Service Requirement	Met	Not Met	Planned Date of Compliance	Verified Compliance	Comments/Notes
addressed in the plan of care, and is reviewed by the participant's physician, nurse practitioner, or pharmacist as part of developing the plan of care and at time of plan review.					
4. For "as needed" or "p.r.n.", orders must be followed exactly as they are written; specifically when, how much and how often it may be administered.					
5. Self-Medication: Participants have a physician/nurse practitioner's written order of approval to self-medicate.					
6. Each medication container is clearly labeled with the pharmacist's label or is in the original labeled container or bubble pack.					
7. All staff must have ready access to participant's medications and be able to access them per the participant's request.					
8. Participant's must not have access to other participant's medications, and no medications will be allowed to be kept in participant's possession while in ADS facility.					
9. Provider Assisted Medication: For some participants, it will be necessary that the provider					

Adult Day Service Requirement	Met	Not Met	Planned Date of Compliance	Verified Compliance	Comments/Notes
oversees the participant's medicine intake as follows:					
a. A current, written medication administration record is kept for each participant and identifies all of the medications administered by the staff to the participant, including over-the-counter medications and prescribed dietary supplements.					
b. Discontinued or changed medication orders are marked and dated on the medication administration record as discontinued.					
c. Missed or refused medication, treatment or therapy is documented the initials must be circled and a brief but complete explanation must be recorded on the back of the medication record.					

Site visit Comments:

Please check the appropriate box below to indicate from which funding source(s) you are interested in obtaining an agreement to provide adult day care services.

Indicate Level(s) of Service:

Basic (I) Enhanced (II) Intensive (III)

- ❑ **MEDICAID HOME AND COMMUNITY-BASED SERVICES WAIVERS**
- ❑ **CHOICE**
- ❑ **TITLE III**
- ❑ **SOCIAL SERVICES BLOCK GRANT (SSBG)**

Provider Name:_____

Administrator Title:_____

Administrator Signature:_____

Date:_____

Inspection Documentation by FSSA Inspector or FSSA Designee

_____	_____
Assessor Name	Date
_____	_____
Assessor Name	Date
_____	_____
Assessor Name	Date

"People helping people help themselves"

Mitchell E. Daniels, Jr., Governor
State of Indiana

Division of Aging
402 W. WASHINGTON STREET, P.O. BOX 7083
INDIANAPOLIS, IN 46207-7083

E. Mitchell Roob, Jr. Secretary

FSSA DIVISION OF AGING

Policy Statement: 06-001 Revision
Date of Notice Issued: 04-21-2006

Issued to: Nursing Facility Level of Care (NF LOC) Medicaid Waiver Providers of Home and Community Based Services (HCBS)
Area Agencies on Aging (AAA)
Case Managers

Authored by: Stephen A. Smith, Director, FSSA Division of Aging

Policy Topic: Requirement of NF LOC Medicaid Waiver Providers to be CHOICE Providers

Impacts the following Waivers: All NF LOC Medicaid Waivers

Effective Date: 07-01-2006

Description of Policy Change, Update or Clarification:

On 12/06/2004, all HCBS Providers were given notification that in order for the provider to provide and be paid for HCBS through CHOICE, they would also be required to enroll as a Medicaid Waiver Provider. The deadline for that action was 01/01/2005.

As of 07/01/2006, the rates for both CHOICE services and NF LOC Medicaid Waiver services will undergo significant changes. In order to ensure that consumers of both programs will served, providers of HCBS must be accessible to both groups of recipients.

NF LOC Medicaid Waiver Providers who are not currently enrolled as CHOICE HCBS Providers are now required to do so. To do this, NF LOC Medicaid Waiver Providers must contact the local AAA's that cover the counties in which they provide services under the Waiver, and make application to become a CHOICE Provider in those same counties only for those same services, that they provide through the Medicaid Waiver. This action should be completed by 05/15/2006 in order that they may be available as providers to those on CHOICE by 07/01/2006. The following exceptions will apply, in that CHOICE Providers will not be providing the following community residential and case management services:

- Assisted Living
- Adult Foster Care
- Case Management

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NURSING FACILITY LEVEL OF CARE WAIVER
PROVIDER INFORMATION
WEBSITES

Aging Rule, 460 IAC 1.2 (effective 10/1/2006)

http://www.in.gov/legislative/iac/iac_title?iact=460 (underscore between the second "iac" and the word "title")

Indiana OPTIONS (Division of Aging website)

www.ltcoptions.in.gov

EDS Website:

www.indianamedicaid.com

Waiver Provider Manual:

www.indianamedicaid.com/ihcp/publications/manuals.html (will be added to the Publications tab at the EDS website in the near future. A printed copy can be ordered from BDDSHelp@fssa.in.gov

Consumer Guide to Indiana Medicaid Waiver Home and Community Based Services Waiver Programs:

http://www.in.gov/gpcpd/publications#4

Questions or further information? Call the Division of Aging 317-232-7122

MEDICAID WAIVER PROVIDER
Application for Certification
For Home and Community Based Service (HCBS) Provision through the following Nursing Facility Level of Care Waiver(s)

Part 1. **Demographic Information**
Check all that apply

☐ Aged and Disabled (A&D) ☐ Traumatic Brain Injury (TBI)

_____ Check one: ☐ New Application ☐ Additional Services
Date of Application

_____
Legal Name (of person or agency)

_____
DBA (Doing Business As) if applicable

_____
Street Address (If additional service locations, please supply all information on this page for each location.)

_____ _____ _____
City State Zip Code

(___)_____ (___) _____ _____
Phone Fax E-Mail Address

_____
CEO/Administrator

_____ _____
Contact Person Title

Type of Provider Entity (Check only one):

☐ Individual _____ _____
Social Security Number (SSN) Medicaid Number

☐ Agency/Corporation _____
Federal ID Number

If Agency, specify type:

☐ Adult Day Services
☐ Adult Foster Care Home
☐ Assisted Living Facility
☐ Division of Disability and Rehabilitative Services (DDRS) Approved Agency
☐ Contractor/Construction
☐ Home/Community Service Agency (unlicensed)
☐ Home Health Agency (licensed)
☐ Retail Vendor
☐ Other (specify):_____

Part 2. MINIMUM QUALIFICATIONS FOR SERVICE PROVIDERS

All service providers (agency or individual) for the Nursing Facility Level of Care Medicaid waivers must be certified by the FSSA or its designee. This certification includes but is not limited to the completion and approval of the Waiver Application. All providers must abide by all of the provisions listed in their state licenses (if applicable), the Medicaid Waiver Provider Agreement and all other specified provisions as required by FSSA. A provider must have a valid signed Notice of Action (NOA) that specifies the service, the amount of units, and the effective date of the services, prior to providing services. The provider cannot at any time require the client to sign an agreement to pay any additional amount of money for services that they have agreed to provide under the waiver.

General Agency Requirements

a. Must comply with any applicable federal, state, county, municipal regulations that govern the operations of the agency; and all FSSA laws, rules, policies; and any applicable licensure or certification requirements
b. Must prove that appropriate and comprehensive insurance is in force
c. Must provide proof that any individual employed by the agency meets all standards and requirements for the specific services of a waiver that the individual will be providing
d. Must provide required training for any individual providing services for the waiver
e. Must provide copies of all applicable licenses
f. All agencies not licensed by the Indiana State Department of Health must obtain and submit a report (that is within the last 90 days) from the Nurse Aide Registry of the Indiana State Department of Health verifying that each employee or agent involved in the direct provision of services has not had a finding entered into the registry
g. Must show proof that all RNs and LPNs on staff have had records checked through the Indiana Health Professions Bureau
h. All agencies not licensed by the Indiana State Department of Health must obtain and submit a limited criminal history (that is within the last 90 days) from each employee involved in the direct management, administration, or provision of services from: The Indiana State Police Central Repository at 100 N. Senate Ave., Room N302, Indianapolis, IN 46204, 317-233-5424; and the county or counties of residence in the last 3 years

General Individual Requirements

a. Must be at least 18 years of age
b. Must demonstrate an ability to read and write adequately to complete required activities and meet service requirements
c. Must demonstrate the ability to understand, read and write adequately to provide the services according to the plan of care for the client
d. Must possess interpersonal skills necessary to work productively and cooperatively with clients of the waiver services and other service providers
e. Must be in adequate physical health and free from physical limitations which would interfere with the ability to perform the tasks required
f. Must be willing and able to accept on-going training as required or necessary
g. Must submit proof that appropriate liability insurance is in force
h. Must submit verification of freedom from communicable diseases as verified by physician by having a negative TB test or negative chest x-ray that has been completed within the last year
i. Must submit verification of all licenses, certifications, trainings, experiences, or degrees required by a specific service or waiver
j. Must show proof, if an RN or LPN, that record has been checked through the Indiana Health Professions Bureau
k. Must obtain and submit a report (that is within the last 90 days) from the Nurse Aide Registry of the Indiana State Department of Health verifying that there is not a finding entered into the registry if involved in the direct provision of services
l. Must obtain and submit a limited criminal history (that is within the last 90 days) from: The Indiana State Police Central Repository at 100 N. Senate Ave., Room N302, Indianapolis, IN 46204, 317-233-5424; and the county or counties of residence in the last 3 years if involved in the direct management, administration, or provision of services

Part 3. Specific Certification Requirements

For Home/Community Service Agencies that provide any or all of the following services:

Attendant Care, Homemaker, Respite Attendant Care, Respite Homemaker Services, Transportation

In addition to the completion of the Provider Application, the agency must comply with the following:

Agency Assurances

- Must be a recognized legal entity authorized to do business in the State of Indiana
- Must submit proof of Articles of Incorporation, Certificate of Incorporation, Organization, or Articles of Authority from the Secretary of State of Indiana
- Must submit proof of comprehensive insurance coverage
- Comply with all relevant federal, state, local, or municipal laws and regulations that govern the operation of the legal entity and the program
- Have a written drug free workplace policy
- Have a staff training plan
- Have back up staffing plan in place to ensure client coverage, and procedures in place to notify clients of any schedule changes
- Perform Client Satisfaction/Evaluation surveys annually
- Must submit list of all employees' names and job titles

Personnel Requirements

- Limited criminal history check from the Indiana State Police Central Repository at 100 N. Senate Ave., Room N302, Indianapolis, IN 46204, 317-233-5424; and the county or counties of residence of last 3 years for any individual providing direct management, administration, or provision of services
- Report (within the last 90 days) from the State Nurse Aide Registry of the Indiana State Department of Health verifying no findings are entered into the registry for each employee or agent involved in the direct provision of services
- Free from communicable diseases as verified by physician by having a negative TB test or negative chest x-ray that has been completed within the last year
- Current CPR certification (for employees providing attendant care /or respite attendant care services)
- Verification of Basic First Aid training (for employees providing attendant care and/or any respite services)
- Verification of training and/or experience as an attendant and/or homemaker

Part 4. WAIVER SERVICES/CERTIFICATION REQUIREMENTS

Under each applicable waiver, check all services for which you are applying for certification at this time. Please note that not all services are available on all waivers or for all types of providers.

Service Category	A&D Aged and Disabled	TBI Traumatic Brain Injury	Certification Requirements (in addition to the general requirements previously listed)
Adult Day Service (company) (A&D, TBI)	Level 1 ___ Level 2 ___ Level 3 ___	Level 1 ___ Level 2 ___ Level 3 ___	ADS Standards and Guidelines, application and site survey*
Adult Foster Care (individual) (A&D)	Level 1 ___ Level 2 ___ Level 3 ___ Level 4 ___ Level 5 ___		AFC Standards and Guidelines, application and site survey*
Assisted Living (facility) (A&D, AL)	Level 1 ___ Level 2 ___ Level 3 ___		AL Rule, Assessment Tool*; Residential Care License from ISDH; Housing with Services Disclosure form*
Attendant Care (individual, agencies) (A&D, TBI, MFC)			Individual: resume; current CPR; Home Community Services Agency guidelines; Community DD agency subject to BDDS approval.
Behavior Management (individual, agencies) (TBI)		Level 1 ___ Level 2 ___	Level 1: Psychologist and Health Services Provider in Psychology (HSPP) endorsement; Level 2: copy of Master's degree, copy of license (if applicable) and resume; Community DD agency subject to BDDS approval
Case Management (individual, agencies) (A&D, MFC, AL, TBI)			Individual certification is through their local Area Agency on Aging (AAA)
Congregate Care (A&D)	Level 1 ___ Level 2 ___ Level 3 ___		
Environmental Modifications (individual, agencies) (A&D, TBI, MFC)			Statement of Assurances and Compliance to ADA guidelines*; Individual: proof of insurance
Health Care Coordination (licensed home health agencies) (TBI)			copies of LPN and RN licenses; verification of Medicaid certification.
Home Delivered Meals (agencies) (A&D)			separate application*
Homemaker (individual, agencies) (A&D, TBI)			Home Community Services Agency guidelines; Community DD agency subject to BDDS approval; Individual: requires resume.
Personal Emergency Response Systems (individual, agencies) (A&D, TBI)			verification of qualified contractor (business or individual) and/or retail license
Physical Therapy (individual, agencies) (TBI)			
Occupational Therapy (individual, agencies) (TBI)			
Residential Habilitation (agencies) (TBI)			subject to BDDS approval

Service Category	A&D Aged and Disabled	TBI Traumatic Brain Injury	Certification Requirements (in addition to the general requirements previously listed)
Respite Attendant Care (individual, agencies) (A&D, TBI)			Home Community Services Agency guidelines; Community DD agency subject to BDDS approval; Individual: requires resume; first aid training; CPR
Respite Home Health Aide (licensed home health agencies) (A&D, TBI)			
Respite Homemaker (individual, agencies) (A&D, TBI)			Home Community Services Agency guideline; Community DD agency subject to BDDS approval; Individual: requires resume; first aid training
Respite LPN (licensed home health agencies) (A&D, TBI, MFC)			
Respite RN (licensed home health agencies) (A&D, TBI, MFC)			
Specialized Medical Equipment and Supplies (individual, agencies) (A&D, TBI)			verification of qualified contractor (business or individual) and/or retail license; verification as required by the Registry for Interpreters of the Deaf (TBI)
Speech/Language Hearing Therapy (individual, agencies) (TBI)			
Structured Day Program (agencies) (TBI)			subject to BDDS approval; verification of CARF certification.
Supported Employment (agencies) (TBI)			subject to BDDS approval; verification of CARF certification
Transportation (agencies) (A&D, TBI)			Community DD agency subject to BDDS approval; verification of Medicaid certification; Statement of Assurances and Compliance for Transportation*
Vehicle Modification (individual, agencies) (A&D, TBI, MFC)			verification of qualified automotive vehicle specialist.

*For additional applications and resources specified in this application, contact 317-232-7122.

Part 5. Medicaid Waiver Provider's Statement of Assurances and Compliance

Check off the assurances before signing. Signatures must be from an individual authorized to sign for the provider entity.

☐ 1. Provider assures that, if approved, the provider entity complies and will maintain compliance with all requirements as specified in this application, and all applicable state and federal statues, regulations and licensure requirements for the approved service(s).

☐ 2. Provider assures that, if approved, the provider entity will provide only those Medicaid Home and Community Based Service(s) which have been authorized in the recipient's individual Plan of Care/Cost Comparison Budget, and in accordance with the Provider Agreement. and Certification requirements.

Signature: _____

Printed Name: _____

Title: _____

Date: _____

Submit the entire completed application, including the signed Statement of Assurances and Compliance, and all documentation for specified certification requirements.

Incomplete applications will be returned.

Mail application and all supporting documents to:

Linda Wolcott, Waiver Operations
MS 21 Division of Aging
402 West Washington Street, Room W454
P.O. Box 7083
Indianapolis, In 46207-7083
Phone (317) 234-0373
Fax (317) 232-7867

SCHEDULE A
INDIANA FAMILY AND SOCIAL SERVICES ADMINISTRATION
MEDICAID HOME AND COMMUNITY-BASED SERVICES
WAIVER PROVIDER AGREEMENT

Provider agrees to provide only those Medicaid Home and Community-Based Services which meet the following criteria:

1. Services which the Provider is licensed or certified to provide (if applicable);
2. Services for which the Provider has received formal certification form the Medicaid Waiver certification;
3. Services which have been authorized by the recipient's waiver case manager or targeted case manager (as appropriate) as set out in the recipient's Plan of Care; and
4. If applicable, in accordance with any addendum to this Agreement

Provider Name: _____

Doing Business As (if legal name is different from provider name stated above). If DBA name is different from provider name, provide documentation:
_____

Home Office address: _____

Mailing address: _____

Pay To address: _____

Service Location(s) (if different from above): _____
_____

Telephone Number: _____

E-mail address: _____

Social Security # or Federal ID# (not both): _____

Check one of the following: _____Individual____ Partnership
_____Corporation _____ Not-For-Profit

List current Medicaid Provider Number, if any: _____
List current Medicaid Waiver Provider number, if known: _____
List current Medicare Provider Number, if any, **and specify type (i.e., home health agency, AAA, etc.):**
_____
Typed or Printed Name of Authorized Representative: _____

Title: _____ Date: _____

INDIANA FAMILY AND SOCIAL SERVICES ADMINISTRATION
MEDICAID HOME AND COMMUNITY BASED SERVICES
WAIVER PROVIDER AGREEMENT

By execution of this Agreement, the undersigned entity ('Provider") requests enrollment as a provider of services or supplies to recipients of Home and Community-Based Services authorized under the Medicaid Home and Community-Based Services Waiver Programs (hereinafter, "Medicaid Waiver"'), and as a condition of enrollment, Provider agrees:

1. To comply, on a continuing basis, with all enrollment requirements established under rules adopted by the State of Indiana Family and Social Services Administration (IFSSA).

2. To comply with all federal and state statutes and regulations pertaining to the Medicaid Program including the Medicaid Waiver Program, as they may be amended from time to time.

3. To meet, on a continuing 'basis, the state and federal licensure, certification or other regulatory requirements for Provider's specialty including all provisions of the State of Indiana Medical Assistance law, State of Indiana's Medicaid Waiver program, or any rule or regulation. promulgated pursuant thereto.

4. To notify IFSSA or its agent within then (10) days of any change in the status of Provider's license, certification or permit to provide its services to the public in the State of Indiana.

5. To provide Medicaid Waiver-covered services and/or supplies for which federal financial participation is available for Medicaid Waiver recipients pursuant to all applicable federal and state statutes and regulations.

6. To safeguard information about Medicaid recipients, including at least:

    a. recipient's name, address, and social and economic circumstances;
    b. medical services provided to recipients;
    c. recipient's medical data, including diagnosis and past history of disease or disability;
    d. any information received for verifying recipient’s income eligibility and amount of medical assistance payments;
    e. any information received in connection with the identification of legally liable third party resources.

7. To release information about Medicaid recipients only to the I FSSA, its agent, or a Medicaid Wavier recipients case manager or targeted case manager and only when in connection with:

    a. Providing services for recipients; and
    b. Conducting or assisting an investigation, prosecution, or civil or criminal proceeding related to the provision of Medicaid covered services.

8. To maintain a written - contract with all subcontractors which fulfills the requirements that are appropriate to the service or activity delegated under the subcontract. No subcontract, however, terminates the 'legal responsibility of the provider to the agency to assure that all activities under the contract are carried out.

9. To submit claims for services rendered by the provider or employees of the provider and not to submit claims for services rendered by contractors unless the provider is a healthcare facility (e.g. hospital, ICF-MR, nursing home) or a government agency with a contract that meets the requirements described in paragraph 8 of this Agreement Healthcare facilities and government agencies' may, under circumstances permitted in federal law, subcontract with other entities or individuals to provide Medicaid-covered services rendered pursuant to this Agreement .

10. To comply, if a hospital, nursing facility, provider of home health care and personal care services, hospice, or HMO; with advance directive requirements as required by 42 'Code of Federal Regulations, parts 489, subpart I, and 417.436.

11. To abide by the Indiana Health Coverage Programs Provider Manual, as amended from time to time, the Medicaid Waiver Programs Provider Manual, as amended from time to time, as well as all provider bulletins and' notices. Any amendments to the Indiana Health Coverage Programs Provider Manual, the Medicaid Waiver Program, as well as provider bulletins and notices communicated to Provider shall be binding upon receipt. Receipt of amendments, bulletins and notices by Provider shall be presumed when mailed to the billing Provider's current "mail to" on file with IFSSA or its fiscal agent.

12. To submit timely billing on Medicaid approved claim forms, as outlined in the Medicaid Waiver Programs Provider Manual, in an amount no greater than Provider's usual and customary charge to the general public for the same service.

13. To be individually responsible- and accountable for the completion, accuracy, and validity of all claims filed under the provider number issued, including claims filed by the Provider, the Provider's employees, or the Provider's agents. Provider understands that the submission of false claims, statements, and documents or the concealment of material fact may be prosecuted under the applicable Federal and/or State law.

14. To submit claim(s) for Medicaid Waiver reimbursement only after first exhausting all other sources of reimbursement as required by the Indiana Health Coverage Programs Provider Manual, bulletins, and banner pages.

15. To submit claim(s) for Medicaid Waiver reimbursement utilizing the appropriate claims forms and, codes as specified in the Medicaid Waiver Programs Provider Manual, bulletins, and notices.

16. To submit claims that can be documented by Provider as being strictly for:

    a. those services and/or supplies authorized by the recipients waiver case manager or targeted case manager for individuals with developmental disabilities; . .
    b. those services and/or supplies actually provided to the recipient in whose name the claim is being made; and
    c. compensation that Provider is legally entitled to receive.

17. To accept payment as payment in full the amounts determined by IFSSA or its fiscal agent in accordance with federal and state statutes and regulations as the appropriate payment for Medicaid waiver covered services provided to Medicaid Waiver recipients. Provider agrees not to bill recipients or any member of a recipient's family, for any additional charge for Medicaid Waiver covered services, excluding and co-payment permitted by law.

18. To refund within fifteen (15) days of receipt, to IFSSA or its fiscal agent any duplicate or erroneous payment received.

19. To make repayments to IFSSA or its fiscal agent or arrange to have future payments from the Medicaid or Medicaid Waiver programs withheld, within sixty (60) days of receipt of notice from IFSSA . or its fiscal agent that an investigation or audit has determined that an overpayment to Provider has been made, unless an appeal of the determination is pending.

20. To pay interest on overpayment in accordance with IC 12-15-13-3, IC 12-15-21-3, and IC 12-15-23-2.

21. To make full reimbursement to IFSSA or its fiscal agent of any federal disallowance incurred by IFSSA when such disallowance relates to payments previously made to Provider under the Medicaid or Medicaid Waiver programs.

22. To fully cooperate with federal and state officials and their agents as they conduct periodic inspections, reviews and audits.

23. To make available upon demand by federal and state officials and their agents all records and information necessary to assure the appropriateness of Medicaid or Medicaid waiver payments made to Provider, to assure the proper administration of the Medicaid and Medicaid Waiver programs and to assure Provider's compliance with all applicable statutes and regulations. Such records and information are specified in' the "Provider Requirements" Section of the Waiver. Provider Manual and shall include, without being limited to, the following: *(405/AC* 1-5)

    a. Medical records as specified by Section 1902(a) (27) of Title XIX of the. Social Security Act and any amendments thereto;
    b. records of all treatments, drugs, services and/or supplies for which vendor payments have been made, or are to be made under the Title XIX Program, including the authority for and the date of administration of such treatment, drug, services and/or supplies;
    c. any records determined by IFSSA or its representative to be necessary to fully disclose and document the extent of services provided to individuals receiving assistance under the provisions of the Indiana Medicaid program;
    d. documentation in each recipient's record that will" enable the IFSSA or its agent to verify that each charge is due and proper;
    e. financial records maintained in the standard, specified form;
    f. all other records as may be found necessary by the IFSSA or its agent in determining compliance with any Federal or State law, rule, or regulation promulgated by the United States Department of Health and Human Services or by the IFSSA.

24. To cease any conduct that IFSSA or its representative deems to be abusive of the Medicaid or Medicaid Waiver programs.

25. To promptly correct deficiencies in Provider's operations upon request of IFSSA or its fiscal agent.

26. To file all appeal requests within the time limits listed below. Appeal requests must state facts demonstrating that:

    a. the petitioner is a person to whom the order is specifically directed;
    b. the petitioner is aggrieved or adversely affected by the order; and
    c. the petitioner is entitled to review under the law.

27. Provider must file a statement of issues within the time limits listed below, setting out in detail:
    a. the specific findings, actions, or determinations of IFSSA from which Provider is appealing;
    b. with respect to each finding, action or determination, all statutes or rules supporting Provider's contentions of error.

28. Time limits for filing an appeal and the statement of issues are as follows:

    a. The provider must file an appeal of determination that an overpayment has occurred within sixty (60) days of receipt of IFSSA's determination. The statement of issues must be filed within 60 days of receipt of IFSSA's determination.
    b. All appeals of actions not described in (a) must be filed within fifteen (15) days of receipt of IFSSA's determination. The statement of issues must be filed within. Forty-five (45) days of receipt of IFSSA's determination.

29. To cooperate with IFSSA or its agent in the application of utilization controls as provided in federal and state statutes and regulations as they may be amended from time to time.

30. To comply with civil rights requirements as mandated by federal and state statutes and regulat10ns by ensuring that no person shall on the basis of race, color, national origin, ancestry, disability, age, sex, or religion be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination in the provision of a Medicaid or Medicaid Waiver-covered service.

31. To comply with 42 Code of Federal Regulations, part 455, .subpart B pertaining to the disclosure of information concerning the ownership and control of the provider, certain business transactions, and information concerning persons convicted of crimes. Said compliance will include, but is not limited to, giving written notice to I FSSA, the State's Medicaid. Waiver Specialist and its fiscal agent, at least sixty (60) days before making a change in any of the following: Name (legal name, DBA name, or name as registered with the Secretary of State), address (service location," pay to," "mail to,", or home office), federal tax identification number(s), or change in the provider's direct or indirect 'ownership' interest or controlling interest. Pursuant to 42 Code of Federal Regulations, part 455.104(c), IFSSA must terminate an existing provider agreement if a provider fails to disclose ownership or control information as required by federal law.

32. To furnish to IFSSA or its agent, as a prerequisite to the effectiveness of this Agreement, the information and documents set out in Schedule A t to this Agreement, which is incorporated here by reference, and to update this information as it may be necessary.

33. That subject to item 32, this Agreement shall be effective as of the date set out in the provider notification letter.

34. If the Provider provides direct services, to provide waiver' services solely as authorized in the recipients Plan of Care/Cost Comparison Budget prepared by the recipients case manager or targeted case manager and as the services are defined in the Medicaid Waiver Provider Manual and the appropriate waiver.

35. To provide at least 30 (thirty) days written notice to the recipient and/or recipient's legal representative, the recipient's case manager or targeted case manager, if applicable, and the State's Medicaid Waiver Specialist before terminating waiver services to a recipient

    a. If the Provider is providing direct services, prior to terminating services, the Provider shall participate in an Interdisciplinary Team meeting to coordinate the transfer of services to a new provider. The Provider agrees to continue serving the recipient until a new provider providing 'similar services is in place, unless written permission has been received from the State's Medicaid Waiver Specialist authorizing the provider to cease providing services before a new provider begin providing.

    b. If the Provider is providing case management services, the Provider shall participate in an Interdisciplinary team meeting, at which the recipient's new case manager is present. The purpose of the Interdisciplinary meeting will be to coordinate the transfer of case management services to the new case manager. The Provider agrees to continue serving the recipient until a new case manager is serving the recipient, unless written permission has been received from the' State's Medicaid Waiver Specialist authorizing the Provider to cease providing services before a new provider begins providing services.

36. To report any incidents (including suspected abuse, neglect or exploitation) to Adult Protective Services or Child Protective Services, the appropriate Area Agency on Aging and the recipient's case manager. If the waiver recipient is developmentally disabled a report shall also be made to the Bureau of Developmental Disabilities Services

37. To comply with Provider and Case Management Standards issued by the Division of Disability, Aging, and Rehabilitative Services, as applicable, and as amended from time to time. These standards are binding upon receipt unless otherwise stated. Receipt will be presumed when the standards or any amendments are mailed to the Provider's current address on file with IFSSA or its fiscal agent.

38. That this Agreement may be terminated as-follows:

    A. By IFSSA or its fiscal agent for Provider's breach of any provision of this Agreement;
    B. By IFSSA or its fiscal agent, or by Provider, upon 60 days written notice.

39. That this Agreement, upon execution, .supersedes and replaces any provider agreement previously executed by the Provider.

THE UNDERSIGNED, BEING THE PROVIDER OR HAVING THE SPECIFIC AUTHORITY TO BIND THE' PROVIDER TO THE TERMS OF THIS AGREEMENT, AND HAVING READ THIS AGREEMENT AND UNDERSTANDING IT IN ITS ENTIRETY, DOES HEREBY AGREE, ON BEHALF OF THE PROVIDER AS A BUSINESS ENTITY, TO ABIDE BY AND COMPLY WITH ALL OF THE STIPULATIONS, CONDITIONS AND TERMS SET FORTH HEREIN.

THE UNDERSIGNED ACKNOWLEDGES THAT THE COMMISSION OF ANY MEDICAID RELATED OFFENSE AS SET OUT IN 42 USC 1320a-7b MAYBE PUNISHABLE BY A FINE OF UP TO $25,000 OR IMPRISONMENT OF NOT MORE THAN FIVE YEARS OR BOTH.

Provider-Authorized Signature - All Schedules
The 9Wner or an authorized officer of the business entity must complete this section

I certify, under penalty of law, that the information stated in Schedule A is correct and complete to the best of my knowledge. I am aware that, should an investigation at any time indicated that the information has been falsified; I may be considered for suspension from the program and/or prosecution for Medicaid Fraud. I hereby authorize the Indiana Family and Social Services Administration to make any necessary verifications of the information provided herein, and further authorize and request each educational institution, medical/license board or organization to provide all information that may be required in connection with my application for participation in the Indiana Medicaid Waiver Program.

Provider DBA Name_____

Tax ID _____

Officer Name _____ Title _____

Signature _____ Date _____

Telephones Number _____

Note: Failure to complete this section will result in the State returning the application for incomplete information.

Revised 1/2002

Form **W-9**
(Rev. January 2005)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give form to the requester. Do not send to the IRS.

Print or type See Specific Instructions on page 2.

Name (as shown on your income tax return)

Business name, if different from above

Check appropriate box: ☐ Individual/ Sole proprietor ☐ Corporation ☐ Partnership ☐ Other ▶ .....

☐ Exempt from backup withholding

Address (number, street, and apt. or suite no.)

Requester's name and address (optional)

City, state, and ZIP code

List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on Line 1 to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. *If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.*

Social security number

or

Employer identification number

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. person (including a U.S. resident alien).

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. (See the instructions on page 4.)

Sign Here Signature of U.S. person ▶ Date ▶

Purpose of Form

A person who is required to file an information return with the IRS, must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

U.S. person. Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee.

Note. *If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.*

For federal tax purposes you are considered a person if you are:

- An individual who is a citizen or resident of the United States,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States, or
- Any estate (other than a foreign estate) or trust. See Regulations sections 301.7701-6(a) and 7(a) for additional information.

Foreign person. If you are a foreign person, do not use Form W-9. Instead, use the appropriate Form W-8 (see Publication 515, Withholding of Tax on Nonresident Aliens and Foreign Entities).

Nonresident alien who becomes a resident alien. Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a "saving clause." Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the recipient has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on an exception contained in the saving clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement to Form W-9 that specifies the following five items:

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.
2. The treaty article addressing the income.
3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.

4. The type and amount of income that qualifies for the exemption from tax.

5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.

Example. Article 20 of the U.S.-China income tax treaty allows an exemption from tax for scholarship income received by a Chinese student temporarily present in the United States. Under U.S. law, this student will become a resident alien for tax purposes if his or her stay in the United States exceeds 5 calendar years. However, paragraph 2 of the first Protocol to the U.S.-China treaty (dated April 30, 1984) allows the provisions of Article 20 to continue to apply even after the Chinese student becomes a resident alien of the United States. A Chinese student who qualifies for this exception (under paragraph 2 of the first protocol) and is relying on this exception to claim an exemption from tax on his or her scholarship or fellowship income would attach to Form W-9 a statement that includes the information described above to support that exemption.

If you are a nonresident alien or a foreign entity not subject to backup withholding, give the requester the appropriate completed Form W-8.

What is backup withholding? Persons making certain payments to you must under certain conditions withhold and pay to the IRS 28% of such payments (after December 31, 2002). This is called "backup withholding." Payments that may be subject to backup withholding include interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

You will not be subject to backup withholding on payments you receive if you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return.

Payments you receive will be subject to backup withholding if:

1. You do not furnish your TIN to the requester, or

2. You do not certify your TIN when required (see the Part II instructions on page 4 for details), or

3. The IRS tells the requester that you furnished an incorrect TIN, or

4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or

5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See the instructions below and the separate Instructions for the Requester of Form W-9.

Penalties

Failure to furnish TIN. If you fail to furnish your correct TIN to a requester, you are subject to a penalty of $50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

Civil penalty for false information with respect to withholding. If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a $500 penalty.

Criminal penalty for falsifying information. Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Misuse of TINs. If the requester discloses or uses TINs in violation of federal law, the requester may be subject to civil and criminal penalties.

Specific Instructions

Name

If you are an individual, you must generally enter the name shown on your social security card. However, if you have changed your last name, for instance, due to marriage without informing the Social Security Administration of the name change, enter your first name, the last name shown on your social security card, and your new last name.

If the account is in joint names, list first, and then circle, the name of the person or entity whose number you entered in Part I of the form.

Sole proprietor. Enter your individual name as shown on your social security card on the "Name" line. You may enter your business, trade, or "doing business as (DBA)" name on the "Business name" line.

Limited liability company (LLC). If you are a single-member LLC (including a foreign LLC with a domestic owner) that is disregarded as an entity separate from its owner under Treasury regulations section 301.7701-3, enter the owner's name on the "Name" line. Enter the LLC's name on the "Business name" line. Check the appropriate box for your filing status (sole proprietor, corporation, etc.), then check the box for "Other" and enter "LLC" in the space provided.

Other entities. Enter your business name as shown on required Federal tax documents on the "Name" line. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on the "Business name" line.

Note. You are requested to check the appropriate box for your status (individual/sole proprietor, corporation, etc.).

Exempt From Backup Withholding

If you are exempt, enter your name as described above and check the appropriate box for your status, then check the "Exempt from backup withholding" box in the line following the business name, sign and date the form.

Generally, individuals (including sole proprietors) are not exempt from backup withholding. Corporations are exempt from backup withholding for certain payments, such as interest and dividends.

Note. If you are exempt from backup withholding, you should still complete this form to avoid possible erroneous backup withholding.

Exempt payees. Backup withholding is not required on any payments made to the following payees:

1. An organization exempt from tax under section 501(a), any IRA, or a custodial account under section 403(b)(7) if the account satisfies the requirements of section 401(f)(2),

2. The United States or any of its agencies or instrumentalities,

3. A state, the District of Columbia, a possession of the United States, or any of their political subdivisions or instrumentalities,

4. A foreign government or any of its political subdivisions, agencies, or instrumentalities, or

5. An international organization or any of its agencies or instrumentalities.

Other payees that may be exempt from backup withholding include:

6. A corporation,

7. A foreign central bank of issue,

8. A dealer in securities or commodities required to register in the United States, the District of Columbia, or a possession of the United States,

9. A futures commission merchant registered with the Commodity Futures Trading Commission,

10. A real estate investment trust,

11. An entity registered at all times during the tax year under the Investment Company Act of 1940,

12. A common trust fund operated by a bank under section 584(a),

13. A financial institution,

14. A middleman known in the investment community as a nominee or custodian, or

15. A trust exempt from tax under section 664 or described in section 4947.

The chart below shows types of payments that may be exempt from backup withholding. The chart applies to the exempt recipients listed above, 1 through 15.

IF the payment is for . . .	THEN the payment is exempt for . . .
Interest and dividend payments	All exempt recipients except for 9
Broker transactions	Exempt recipients 1 through 13. Also, a person registered under the Investment Advisers Act of 1940 who regularly acts as a broker
Barter exchange transactions and patronage dividends	Exempt recipients 1 through 5
Payments over $600 required to be reported and direct sales over $5,000 [1]	Generally, exempt recipients 1 through 7 [2]

[1] See Form 1099-MISC, Miscellaneous Income, and its instructions.

[2] However, the following payments made to a corporation (including gross proceeds paid to an attorney under section 6045(f), even if the attorney is a corporation) and reportable on Form 1099-MISC are not exempt from backup withholding: medical and health care payments, attorneys' fees; and payments for services paid by a Federal executive agency.

Part I. Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. If you are a resident alien and you do not have and are not eligible to get an SSN, your TIN is your IRS individual taxpayer identification number (ITIN). Enter it in the social security number box. If you do not have an ITIN, see *How to get a TIN* below.

If you are a sole proprietor and you have an EIN, you may enter either your SSN or EIN. However, the IRS prefers that you use your SSN.

If you are a single-owner LLC that is disregarded as an entity separate from its owner (see *Limited liability company (LLC)* on page 2), enter your SSN (or EIN, if you have one). If the LLC is a corporation, partnership, etc., enter the entity's EIN.

Note. See the chart on page 4 for further clarification of name and TIN combinations.

How to get a TIN. If you do not have a TIN, apply for one immediately. To apply for an SSN, get Form SS-5, Application for a Social Security Card, from your local Social Security Administration office or get this form online at *www.socialsecurity.gov/online/ss-5.pdf*. You may also get this form by calling 1-800-772-1213. Use Form W-7, Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN, or Form SS-4, Application for Employer Identification Number, to apply for an EIN. You can apply for an EIN online by accessing the IRS website at *www.irs.gov/businesses/* and clicking on Employer ID Numbers under Related Topics. You can get Forms W-7 and SS-4 from the IRS by visiting *www.irs.gov* or by calling 1-800-TAX-FORM (1-800-829-3676).

If you are asked to complete Form W-9 but do not have a TIN, write "Applied For" in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, generally you will have 60 days to get a TIN and give it to the requester before you are subject to backup withholding on payments. The 60-day rule does not apply to other types of payments. You will be subject to backup withholding on all such payments until you provide your TIN to the requester.

Note. Writing "Applied For" means that you have already applied for a TIN or that you intend to apply for one soon.

Caution: *A disregarded domestic entity that has a foreign owner must use the appropriate Form W-8.*

Part II. Certification

To establish to the withholding agent that you are a U.S. person, or resident alien, sign Form W-9. You may be requested to sign by the withholding agent even if items 1, 4, and 5 below indicate otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required). Exempt recipients, see *Exempt From Backup Withholding* on page 2.

Signature requirements. Complete the certification as indicated in 1 through 5 below.

1. Interest, dividend, and barter exchange accounts opened before 1984 and broker accounts considered active during 1983. You must give your correct TIN, but you do not have to sign the certification.

2. Interest, dividend, broker, and barter exchange accounts opened after 1983 and broker accounts considered inactive during 1983. You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item 2 in the certification before signing the form.

3. Real estate transactions. You must sign the certification. You may cross out item 2 of the certification.

4. Other payments. You must give your correct TIN, but you do not have to sign the certification unless you have been notified that you have previously given an incorrect TIN. "Other payments" include payments made in the course of the requester's trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services (including payments to corporations), payments to a nonemployee for services, payments to certain fishing boat crew members and fishermen, and gross proceeds paid to attorneys (including payments to corporations).

5. Mortgage interest paid by you, acquisition or abandonment of secured property, cancellation of debt, qualified tuition program payments (under section 529), IRA, Coverdell ESA, Archer MSA or HSA contributions or distributions, and pension distributions. You must give your correct TIN, but you do not have to sign the certification.

What Name and Number To Give the Requester

For this type of account:	Give name and SSN of:
1. Individual	The individual
2. Two or more individuals (joint account)	The actual owner of the account or, if combined funds, the first individual on the account [1]
3. Custodian account of a minor (Uniform Gift to Minors Act)	The minor [2]
4. a. The usual revocable savings trust (grantor is also trustee)	The grantor-trustee [1]
b. So-called trust account that is not a legal or valid trust under state law	The actual owner [1]
5. Sole proprietorship or single-owner LLC	The owner [3]
For this type of account:	**Give name and EIN of:**
6. Sole proprietorship or single-owner LLC	The owner [3]
7. A valid trust, estate, or pension trust	Legal entity [4]
8. Corporate or LLC electing corporate status on Form 8832	The corporation
9. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
10. Partnership or multi-member LLC	The partnership
11. A broker or registered nominee	The broker or nominee
12. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments	The public entity

[1] List first and circle the name of the person whose number you furnish. If only one person on a joint account has an SSN, that person's number must be furnished.

[2] Circle the minor's name and furnish the minor's SSN.

[3] You must show your individual name and you may also enter your business or "DBA" name on the second name line. You may use either your SSN or EIN (if you have one). If you are a sole proprietor, IRS encourages you to use your SSN.

[4] List first and circle the name of the legal trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.)

Note. If no name is circled when more than one name is listed, the number will be considered to be that of the first name listed.

Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to provide your correct TIN to persons who must file information returns with the IRS to report interest, dividends, and certain other income paid to you, mortgage interest you paid, the acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA, or Archer MSA or HSA. The IRS uses the numbers for identification purposes and to help verify the accuracy of your tax return. The IRS may also provide this information to the Department of Justice for civil and criminal litigation, and to cities, states, and the District of Columbia to carry out their tax laws. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You must provide your TIN whether or not you are required to file a tax return. Payers must generally withhold 28% of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to a payer. Certain penalties may also apply.

COUNTY SURVEY

Provider Name: _____

Doing Business as (DBA): _____

Contact Person: _____

Telephone Number: _____

Please circle the number of **each** county in which you are willing to provide the service(s). The Medicaid Waiver Unit database lists waiver providers by the counties they serve; waiver case managers utilize the database to refer waiver clients to providers serving a client's county of residence.

COUNTY	COUNTY	COUNTY
1. ADAMS	32. HENDRICKS	63. PIKE
2. ALLEN	33. HENRY	64. PORTER
3. BARTHOLOMEW	34 HOWARD	65. POSEY
4. BENTON	35. HUNTINGTON	66. PULASKI
5. BLACKFORD	36. JACKSON	67. PUTNAM
6. BOONE	37. JASPER	68. RANDOLPH
7. BROWN	38. JAY	69. RIPLEY
8. CARROLL	39. JEFFERSON	70. RUSH
9. CASS	40. JENNINGS	71. SAINT JOSEPH
10. CLARK	41. JOHNSON	72. SCOTT
11. CLAY	42. KNOX	73. SHELBY
12. CLINTON	43. KOSCIUSKO	74. SPENCER
13. CRAWFORD	44. LAGRANGE	75. STARKE
14. DAVIESS	45. LAKE	76. STEUBEN
15. DEARBORN	46. LAPORTE	77. SULLIVAN
16. DECATUR	47. LAWRENCE	78. SWITZERLAND
17. DEKALB	48. MADISON	79. TIPPECANOE
18. DELAWARE	49. MARION	80. TIPTON
19. DUBOIS	50. MARSHALL	81. UNION
20. ELKHART	51. MARTIN	82. VANDERBURGH
21. FAYETTE	52. MIAMI	83. VERMILLION
22. FLOYD	53. MONROE	84. VIGO
23. FOUNTAIN	54. MONTGOMERY	85. WABASH
24. FRANKLIN	55. MORGAN	86. WARREN
25. FULTON	56. NEWTON	87. WARRICK
26. GIBSON	57. NOBLE	88. WASHINGTON
27. GRANT	58. OHIO	89. WAYNE
28. GREENE	59. ORANGE	90. WELLS
29. HAMILTON	60. OWEN	91. WHITE
30. HANCOCK	61. PARKE	92. WHITLEY
31. HARRISON	62. PERRY	

The list and map on the following pages show each Area Agency on Aging, with the counties included in each AAA's jurisdiction. The Medicaid Waiver Unit suggests that new providers contact each Area Agency in whose counties the provider will deliver waiver services, so the AAA becomes acquainted with new providers in the area. 2/05

16 Area Agencies on Aging

AREA 1
Northwest Indiana Community Action Corp.
5240 Fountain Dr.
Crown Point, IN 46307
(219) 794-1829 or (800) 826-7871
TTY: (888) 814-7597
FAX (219) 794-1860
Web Site: www.nwi-ca.com
E-Mail: golund@nwi-ca.org
Gary Olund, Executive Director
Jennifer Malone, Director of Elderly Services

AREA 2
REAL Services, Inc.
1151 S. Michigan St., P.O. Box 1835
South Bend, IN 46634-1835
(574) 233-8205 or (800) 552-2916
FAX (574) 284-2642
Web Site: www.realservicesinc.com
Becky Zaseck, President, C.E.O

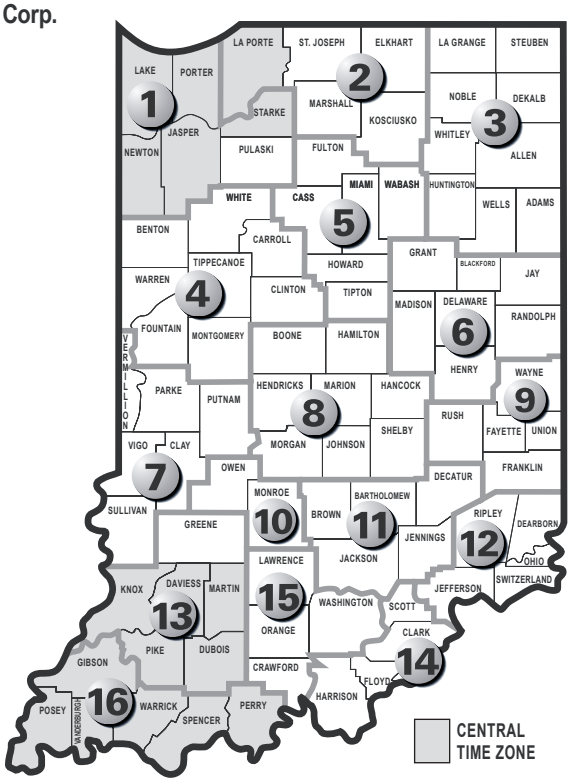
AREA 3
Aging and In-Home Services of Northeast Indiana, Inc.
2927 Lake Avenue
Fort Wayne, IN 46805-5414
(260) 745-1200 or (800) 552-3662
FAX (260) 456-1066
Web Site: www.agingihs.org
E-Mail: dmccormick@agingihs.org
Diann McCormick, President

AREA 4
Area IV Agency on Aging & Community Action Programs, Inc.
660 North 36th St., P.O. Box 4727
Lafayette, IN 47903-4727
(765) 447-7683 or (800) 382-7556
TDD (765) 447-3307; FAX (765) 447-6862
E-Mail: info@areaivagency.org
Web Site: www.areaivagency.org
Sharon Wood, Executive Director

AREA 5
Area Five Agency on Aging & Community Services, Inc.
1801 Smith Street, Suite 300
Logansport, IN 46947-1577
(574) 722-4451 or (800) 654-9421
FAX (574) 722-3447
E-Mail: areafive@areafive.com
Web Site: www.areafive.com
Michael Meagher, Executive Director

AREA 6
LifeStream Services, Inc.
1701 Pilgrim Blvd., P.O. Box 308
Yorktown, IN 47396-0308
(765) 759-1121 or (800) 589-1121
TDD (800) 589-1121; FAX (765) 759-0060
E-Mail: mail@lifestreaminc.org
Web Site: www.lifestreaminc.org
Kenneth D. Adkins, President/CEO

AREA 7
Area 7 Agency on Aging and Disabled West Central Indiana Economic Development District, Inc.
1718 Wabash Ave., P.O. Box 359
Terre Haute, IN 47808-0359
(812) 238-1561 or (800) 489-1561
TDD (800)489-1561; FAX (812) 238-1564
E-Mail: Area7AAD@netscape.net
Mervin Nolot, Executive Director



AREA 8
CICOA Aging and In-Home Solutions
4755 Kingsway Dr., Suite 200
Indianapolis, IN 46205-1560
(317) 254-5465 or (800) 489-9550
FAX (317) 254-5494; TDD (317) 254-5497
Web Site: www.cicoa.org
Duane Etienne, President, C.E.O.

AREA 9
Area 9 In-Home & Community Services Agency
520 South 9th St.
Richmond, IN 47374-6230
(765) 966-1795, (765) 973-8334 or
(800) 458-9345
FAX (765) 962-1190
E-Mail: ashepher@indiana.edu
Web Site: www.iue.indiana.edu/departments/Area 9
Tony Shepherd, Executive Director

AREA 10
Area 10 Agency on Aging
630 W. Edgewood Drive
Ellettsville, IN 47429
(812) 876-3383 or (800) 844-1010
FAX (812) 876-9922
E-Mail: area10@area10.bloomington.in.us
Web Site: www.area10.bloomington.in.us
Jewel Echelbarger, Executive Director

AREA 11
Aging & Community Services of South Central Indiana, Inc.
1531 13th Street, Suite G-900
Columbus, IN 47201-1302
(812) 372-6918 or (866) 644-6407
FAX (812) 372-7846
Web Site: www.agingandcommunityservices.org
E-Mail: dcantrell@areaxi.org
Diane Cantrell, Executive Director

AREA 12
***Life*Time Resources, Inc.**
13091 Benedict Drive
Dillsboro, IN 47018
(812) 432-5215 or (800) 742-5001
FAX (812) 432-3822
Web Site: www.lifetime-resources.org
E-Mail: contactltr@lifetime-resources.org
Sally Beckley, Executive Director

AREA 13
Generations
Vincennes University Statewide Services
1019 North 4th Street
P.O. Box 314
Vincennes, IN 47591
(812) 888-5880 or (800) 742-9002
FAX (812) 888-4566
E-Mail: generations@vinu.edu
Web Site: www.generationsnetwork.org
Anne N. Jacoby, Assistant Vice President

AREA 14
LifeSpan Resources, Inc.
426 Bank Street, Suite 100, P.O. Box 995
New Albany, IN 47151-0995
(812) 948-8330 or (888)948-8330
FAX: (812) 948-0147
E-Mail: kstormes@lsr14.org
Web Site: www.lifespanresources.org
Keith Stormes, Executive Director

AREA 15
Hoosier Uplands/Area 15 Agency on Aging and Disability Services
521 West Main Street
Mitchell, IN 47446
(812) 849-4457 or (800) 333-2451
TDD (800) 743-3333; FAX (812) 849-4467
E-Mail: area15@hoosieruplands.org
Web Site: www.hoosieruplands.org
David L. Miller, CEO
Barbara Tarr, Director of Aging and Disability Services

AREA 16
Southwestern Indiana Regional Council on Aging, Inc.
16 W. Virginia St., P.O. Box 3938
Evansville, IN 47737-3938
(812) 464-7800 or (800) 253-2188
FAX (812) 464-7843 or (812) 464-7811
E-Mail: swirca@swirca.org
Web Site: www.swirca.org
Robert J. "Steve" Patrow, Executive Director

To contact your local Area Agency toll-free, call
1-800-986-3505